

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50 K

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution:

88 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Burtons ville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Marian Evans Auld.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married.6. (b) Name of husband or wife Rev. B. Franklin Auld.

7. Birth date of deceased (mo., day, yr.)

November 2, 1891

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

5488

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

HomeFATHER 12. Name John W. Evans13. Birthplace Deal's Island, MarylandMOTHER 14. Maiden name Margaret Leland15. Birthplace Hoopers Island, Md.16. Informant Hospital records.

Address

17. Burial Date the body was buried (month) (day) (year) July 12 1946
(Burial, cremation, or removal. Which?)Cemetery or crematory London Park
Baltimore, Maryland.

Location

18. Funeral director Wm. E. HumphreyAddress 8434 Lingia Ave. Silver Spring, Md.19. July 11 1946 Sertrude B. Leland
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946, at 7:35 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946, to July 10 1946, and that I last saw him alive on July 10 1946.Immediate cause of death acute cardiac
degeneration.

DURATION

1 hr.Due to Coronary Artery Disease 2 yrs.Due to Pulmonary metastasis 18 mos.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE _____ M. D. or other

Address Sandy Spring, Md. Date signed 7/10/46

RECEIVED
JUL 17 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07103

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co,
County.....
City or town..... Germantown Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md..... County..... Montg
City or town..... Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Sophia F. Baker

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) unknown 6. (c) If alive, give age..... years

8. AGE: Years 83 yrs Months Days If less than one day hrs. min.

9. Birthplace..... Frederick Co, Md writer
(Town, county, and state)

10. Usual occupation..... House Keeping & Writer

11. Industry or business

12. Name..... Andrew Baker
Md,

13. Birthplace..... Annie Boland
Md,

14. Maiden name..... Eula Boland
Md,

15. Birthplace.....

16. Informant..... Gaithersburg Md,
Address

17. Burial 7/10/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Rose Cemetery
Location..... Clopper. Md,

18. Funeral director..... Ernest C Gartner

Address..... Gaithersburg Md,

19. July 9 19 46 Abundant H. Cooke
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 19 46 at 9:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 19 46, to July 6, 19 46

and that I last saw him alive on July 6, 19 46

Immediate cause of death..... Acute Coronary Occlusion DURATION Immediate

Due to..... Genl. Arterial sclerosis 10 yrs.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Upton D. Lounso MD
Hawsonville Md Date signed July 9, 19 46

Address.....

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07104

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Taroma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 monthHospital, institution, or street address where death occurred:
Washington Sanitarium and HospitalHow long in hospital or institution? 1 month (31 days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania CountyCity or town New Tripoli
(If outside city or town limits, write RURAL and give nearest town)Street No. R. R. #1
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Minnie Benkes

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Cauc. Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 18918. AGE: Years 55 Months 2 Days 3 If less than one day
hrs. min.9. Birthplace Tamaqua, Pennsylvania
(Town, county, and state)10. Usual occupation Practical nurse

11. Industry or business

12. Name J. Pestler13. Birthplace Unknown14. Maiden name Caroline Diptertling15. Birthplace Unknown16. Informant Records - Washington San. Hosp.

Address

17. Burial Date thereof July 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory White Church Cem.Location Leak, Pennsylvania18. Funeral director L. H. Niles Co.Address 2901-14th St. N.W. Wash. D.C.19. July 9, 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1946 at 9:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28, 1946 to July 8, 1946and that I last saw her alive on July 8, 1946Immediate cause of death Cardiac failurePractical nurse with failureof heart & kidneys.Due to Aluminum at Heart Riverwith Mitral stenosis &insufficiency & Aorticinsufficiency

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. H. K. Madsen M.D.Washington San. Hosp. M. D. or otherDate signed 7-9-46

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JUL 11 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07105
Reg. Dist. No. 22.3

1. PLACE OF DEATH:

County... Montgomery
 City or town... Tatam Park, Wash. D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? five days
 Hospital, institution, or street address where death occurred
Washington Sanitarium and Hospital
 How long in hospital or institution? five days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Wash. D.C. County... D.C.
 City or town... Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6914 5th Street N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Mrs. Mary Louise Meng-Bass

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Mr. Frank Bass
(Deceased) 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) May 23, 1870
 8. AGE: Years 76 Months 1 Days 17 If less than one day
hrs. min.

9. Birthplace... Rochester, New York
 (Town, county, and state)
 10. Usual occupation... Housewife
 11. Industry or business

12. Name Mr. ? Meng
 13. Birthplace
 14. Maiden name
 15. Birthplace

16. Informant Mrs. Hahn (Harry) Maurer
 Address 6914 5th Street N.W., Wash. D.C.

17. Cremation Date thereof July 12, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery
 Location 3201 Bladensburg Rd. N.E. Washington, D.C.

18. Funeral director W. W. Chambers Co.
 Address 1400 Chapin N.W.

19. July 9 19 46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 9th 19 46 at 7:15 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 4th 19 46 to July 8th 19 46
 and that I last saw him alive on July 8th 19 46
 Immediate cause of death
 ① Acute bilateral obstructive
 ② Pulmonary infarction +
 ③ General peritonitis
 Due to...
 ④ Strangulated femoral hernia
 Due to...
 ⑤ Carcinoma of Breast
 Other conditions
Alcoholic thyroid - subacute
 (Include pregnancy within 3 months of death)
 Major findings of operations... None
 Date of op.
 Autopsy results... As above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION
10 days
5 "
5 "
2 weeks
years 32
" "

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE John A. Brounberger M.D.
 Address Shannon Park - N.W. Date signed 7/9/46

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JUL 12 1946

BUREAU V F

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07106

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? (died enroute)
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? died enroute

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313 Rosemary Street
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

BINGHAM, Donald Cameron, Captain USN

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Bianca C. Bingham

7. Birth date of deceased (mo., day, yr.) August 8, 1882 6. (c) If alive, give age years

8. AGE: Years 63 Months 11 Days 15 If less than one day hrs. min.

9. Birthplace Talladega, Ala.
(Town, county, and state)

10. Usual occupation Navy

11. Industry or business

12. Name John A. Bingham

13. Birthplace Ala. (dec)

14. Maiden name Lillie Scheusler

15. Birthplace Ala. (dec)

16. Informant wife: Mrs. Bianca C. Bingham

Address 313 Rosemary Street, Chevy Chase, Md.

17. burial Date thereof 7-25-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. Chambers

Address 1400 Chapin St. N.W. Wash. D.C.

7-23- 46 Mary Charlotte Smith

19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 July 19 46 at 2:47 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med. Exam Case 19 19
and that I last saw him alive on 19 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Frank J. Brochant M.D.
Dep Med. Exam M. D. or other

Address Washington Md Date signed 7-23-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/26/46

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JUL 29 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

552

07107

CERTIFICATE OF DEATH



Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 3 months, 13 days
 Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution?... 3 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...
 City or town... Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1908 T Place S.E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... World War I

3. (a) FULL NAME

Fred (n) BOOTH

3. (b) Social Security Number

4. Sex... male 5. Color or race... W-US 6. (a) Single, married, widowed, or divorced... married
 6. (b) Name of husband or wife... Mary Booth
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... 3 Sept 89
 8. AGE: Years... 56 Months... 10 Days... 0 If less than one day... hrs. min.

8. Birthplace... Rhode Island
 (Town, county, and state)
 10. Usual occupation... veteran
 11. Industry or business
 12. Name... Fred Booth (dec)
 13. Birthplace... England
 14. Maiden name... Fannie Etchels (dec)
 15. Birthplace... England

16. Informant... Mrs. Mary Booth
 Address... 1908 T Place, S.E. Wash, D.C.
 17. burial Date thereof... 7-6-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Arlington National
 Location... Arlington, Va.
 18. Funeral director... W. W. CHAMBERS
 Address... 517 11th St., S.W., Wash., D.C.
 19. 3 July 19 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 3 July 19 46 at 12:45 am
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
20 March 19 46 to 3 July 19 46
 and that I last saw him alive on 3 July 19 46
 Immediate cause of death... multiple myeloma
 DURATION... ? 6 mos
 Due to...
 Due to...
 Other conditions... Pathological fracture 3 in
left humerus Emphysema left 6 mos
 (Include pregnancy within 6 months of death)
 Major findings of operations...
 Date of op...
 Autopsy results... Multiple myeloma et al (see above)
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?
 23. SIGNATURE...
Frank S. ASHBURN, Lt. Cdr. (MC) USN
 M. D. or other
 Address... USNH Bethesda, Md. Date signed... 7-3-46

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JUL 12 1946
BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

07108

1. PLACE OF DEATH:

County MONTGOMERY
 City or town SILVER SPRING
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
HOLLYWOOD AVE - HOLLYWOOD PARK.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
 City or town SILVER SPRING
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. HOLLYWOOD AVE - HOLLYWOOD PARK.
 (If rural, give LOCATION)
 2.(a) If veteran, name war NONE

3. (a) FULL NAME

Frieda Rosa Braun

3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife KARL G.7. Birth date of deceased (mo., day, yr.) OCT-10TH 1877.

6.(c) If alive, give age _____ years

8. AGE: Years 68 Months 9 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace GERMANY
(Town, county, and state)10. Usual occupation RETIRED

11. Industry or business

12. Name JACOB BLANK.13. Birthplace GERMANY14. Maiden name UNKNOWN.15. Birthplace UNKNOWN.16. Informant MRS. CHARLES J. CASSIDYAddress 1063 MICH. AVE. N.E. WASH. D.C.17. BURIAL Date thereof JULY-27-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PROSPECT HILLLocation WASHINGTON - D.C.18. Funeral director Wm. E. Humphrey -Address SILVER SPRING - MD.19. Date rec'd by registrar July 26 19 46 Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 46 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam case 19 _____ to 19 _____
and that I last saw him alive on 19 _____

Immediate cause of death

Coronary occlusion

DURATION

sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brosehart M.D. M. D. or otherAddress Washington Md Date signed 8-28-46

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JUL 30 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. Mr. Oakdale
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mr. Burton Bready
4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed.

6. (b) Name of husband or wife

8. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) September 31, 1883

8. AGE: Years 62 Months 10 Days 2 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Calvin Bready
13. Birthplace Maryland

14. Maiden name Eliza Bready
15. Birthplace Maryland

16. Informant Hospital record.

Address Burial
17. (Burial, cremation, or removal, which?) Date thereof July 7, 1946
(month) (day) (year)

Cemetery or crematorium Rockville Union Cem.
Location Rockville, Maryland

18. Funeral director Wm. R. Bready
Address Rockville, Maryland

19. 7-6 19 46 Bertrude B. Lawler
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 46 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to July 5 19 46
and that I last saw him alive on July 5 19 46

Immediate cause of death General Carcinomatous DURATION 18 mo

Due to

Due to Carcinoma of Eye & not 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE MS M. D. or other

Address Sandy Spring, Md. Date signed 7/6/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 17 1946

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

Reg. Diat. No. 241

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month - 24 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 1 month - 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County _____
 City or town Sunbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 153 Reagan Street
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Claude Buss

3. (b) Social Security Number

✓

4. Sex Male 5. Color or race Cauc. 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Clara Buss
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 25 1878
 8. AGE: Years 68 Months 2 Days 26 (If less than one day _____ hrs. _____ min.)
 9. Birthplace Sunbury, Pennsylvania
 (Town, county, and state)
 10. Usual occupation Retired railroad man
 11. Industry or business _____
 12. Name _____
 13. Birthplace _____
 14. Maiden name _____
 15. Birthplace _____

16. Informant Records - Washington San. & Hosp.
 Address Takoma Park, Md.
 17. Burial Date thereof July 24 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location Sunbury, Pa.
 18. Funeral director Arthur H. Hester
 Address 254 - Laurel St. Takoma Park, Md.
 19. July 21 1946
 (Date rec'd by registrar) Registrar J. H. Hester

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1946 at 1 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 39 to July 21 1946
 and that I last saw him alive on July 26 1946
 Immediate cause of death Coronary Occlusion DURATION terminal
Arteriosclerosis years _____
 Due to _____
 Due to _____
 Other conditions Diabetes Mellitus 15 yrs.
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results Confirmatory of diagnosis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Robert H. Hester M.D. M. D. or other _____
 Address Takoma Park, Md. Date signed 7/21/46

RECEIVED
JUL 25 1966
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1262

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Haytersville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Theodore Oxyutt. Campbell

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

March 17, 1938

8. AGE: Years Months Days If less than one day

8

Months

4

Days

If less than one day

hrs.

min.

9. Birthplace Haytersville, Maryland
(Town, county, and state)10. Usual occupation School boy11. Industry or business -12. Name Charles Oxyutt13. Birthplace Haytersville, Md.14. Maiden name Ella Campbell15. Birthplace Middlebrook, Md.16. Informant Hospital records

Address

17. Burial
(Burial, cremation, or removal. Which?) Date thereof July 20, 1946
(Month) (day) (year)Cemetery or crematory Brookgrove Md.Location Haytersville Md.18. Funeral director Prof. W. BarkerAddress Haytersville Md.19. July 20, 1946
(Date rec'd by registrar)Gertrude B. Lawler
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 17, 1946 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Ref. Med. Exam case 19. to 19.

and that I last saw him alive on 19.

Immediate cause of death _____ DURATION

Inter-cranial hemorrhage 9 daysDue to fracture of skull(accidental)

Due to _____

Other conditions Compound fracture 9 daysleft arm

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 8, 1946Where did injury occur? Near Haytersville, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) farmMeans of injury Fell out of barn Injured at work?23. SIGNATURE Frank J. Brochant M.D.Ref. Med. Exam M. D. or otherAddress Haytersville Md. Date signed 7-18-46

RECEIVED

AUG 14 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07112

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. CountyCity or town Happy Creek
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war ★ 1 ✓

3. (a) FULL NAME

Forrest E. CARPENTER

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 21 1889

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5676

hrs.

min.

9. Birthplace Pa.

(Town, county, and state)

10. Usual occupation

veteran

11. Industry or business

MOTHER FATHER

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown16. Informant Mr. Russell R. Smedley

Address

Happy Creek, Va.17. removal
(Burial, cremation, or removal. Which?)

Date thereof

7-28-46

(month) (day) (year)

Cemetery or crematory Prospect HillLocation Front Royal, Va.18. Funeral director Meddox Funeral Home, R. H.

Address

105 W. Main St. Front Royal, Va.19. 28 July 19 46

(Date rec'd by registrar)

Mary Charlotte SmithMary Charlotte Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 July 19 46 at 7:19 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 11 19 46 to 27 July 19 46and that I last saw him alive on 27 July 19 46Immediate cause of death congestive failure

DURATION

Due to generalized arteriosclerosis

(marked)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results generalized arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. THOMPSON, Lt. Comdr. (MC) USN

M. D. or other

Date signed 7-28-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/3/46

RECEIVED

AUG 2 1946

BUREAU

07113

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County MontgomeryVillage or City Chesapeake (No. 20, Hesketh St.; Ward)

2 FULL NAME

Ella Chase Clephane

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)6 DATE OF BIRTH Febr 11, 1865
(Month) (Day) (Year)7 AGE 81 yrs. 81 mos. 81 ds. 11 LESS than
1 day, 81 hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) —

PARENTS

10 NAME OF FATHER Lewis Clephane11 BIRTHPLACE OF FATHER (State or country) Wash D.C.12 MAIDEN NAME OF MOTHER Annie M. Collins13 BIRTHPLACE OF MOTHER (State or country) Hartfield Mass

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Clephane(Address) 6000 Conn. Ave., N.W., D.C.15 Filed 7/29/46 Mr E Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29th, 1946
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from April 25, 1946 to July 29, 1946
that I last saw her alive on July 29, 1946
and that death occurred on the date stated above, at 6:27 pm.

The CAUSE OF DEATH was as follows:

Carcinoma of the liverContributory
Secondary(Duration) 3 yrs. — mos. — ds.(Signed) J. C. Birdsall M.D.
7-29-1946 (Address) 1832 - Kal. Rd. Wash D.C.

* State the DISEASE CAUSING DEATH, or, in CONNECTION WITH IT, CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 15 yrs In the State, 15 yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Glenwood Cem., 19—

20 UNDERTAKER ADDRESS

Jos. Gawler Sons Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word, or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

JUL 31 1945

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *ulcers*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bo)

07114

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 39 Days
 Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 39 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Washington, D.C. County Washington, D.C.
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 624 Maryland Ave. N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War II ☒

3. (a) FULL NAME

Joseph Robert COLEMAN

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
 8.(b) Name of husband or wife Mrs. Alice M. Coleman
 6.(c) If alive, give age 39 years
 7. Birth date of deceased (mo., day, yr.) July 3 1912
 8. AGE: Years 34 Months 0 Days 4 If less than one day hrs. min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation veteran
 11. Industry or business
 12. Name Thomas H. Coleman (dec.)
 13. Birthplace virginia
 14. Maiden name Eula J. Rapp (dec.)
 15. Birthplace West Virginia

16. Informant Mrs. Alice M. Coleman
 Address 624 Maryland Ave. N.E. Washington, D.C.
 17. burial Date thereof July 10 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director Lee Funeral Home M.E.M.
 Address 4th & Mass., Ave., N.E. Wash., D.C.
 19. 7-8-46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7-46 19 46 at 11:27pm
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 May 19 46 to 7 July 19 46
 and that I last saw him alive on 19 19 46

Immediate cause of death Congestive heart failure
acute glomerulo-nephritis
 DUE TO 2 days
1 month
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following: _____
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE P. F. Dickens, Jr., Cdr. (MC) USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 7-8-46

RECEIVED
JUL 12 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

07115

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Lewsdale MD. R.F.D. Clarksburg MD
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Three Weeks
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Lewsdale MD. R.F.D. Clarksburg MD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Jesse C. Covell

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Nora B. Covell6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) Oct. 10 1878

8. AGE: Years 67 Months 9 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick Co.
(Town, county, and state)10. Usual occupation Labore

11. Industry or business _____

12. Name Joshua C. Covell13. Birthplace Frederick CO MD.14. Maiden name Mary M. Burdette15. Birthplace Frederick CO. MD.16. Informant Nora B. CovellAddress Clarksburg Md.17. Burial Date thereof July 21 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory MT. OlivetLocation Frederick CO. MD.18. Funeral director Roy W. BarberAddress Laytonsville MD.19. July 18 1946 Della W. Burdette
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1946 at 5 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1943 to July 18, 1946and that I last saw him alive on July 16, 1946Immediate cause of death Arteriosclerotic cardiovascular diseaseDURATION 4 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James B. Kerr M. D. or other _____Address Danvers Md. Date signed 7/18/46

RECEIVED
JUL 24 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.
 City or town Near Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Monty Md. County Monty
 City or town Near Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 Lynn Drive
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

GEORGIA MAY CURRY

3.(b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife William Sheridan Curry

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Feb. 5, 1869

8. AGE:

Years

Months

Days

If less than one day

77515

hrs.

min.

9. Birthplace

(Town, county, and state)

Ohio

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Charles Lyman

13. Birthplace

Ohio

MOTHER

14. Maiden name

Mary Savage

15. Birthplace

Ohio

16. Informant

Harry A. Hansen

Address

300 Lynn Drive, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 27, 1946
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Md.

18. Funeral director

S. J. Hines Co.

Address

2901-14th St. N.W. Wash. D.C.

19.

(Date rec'd by registrar)

7/201946Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 201946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1938 to July 20 1946and that I last saw her alive on July 19 1946

Immediate cause of death

Hypostatic pneumoniaCardiac failureArterio-sclerosis witharterial hypertensionCerebral thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Philip Hansen M.D.

M.D. or other

Address

5424 Leabrook Ave. N.W.

Date signed

July 20, 1946Washington D.C.

DEPARTMENT OF HEALTH

OFFICE OF THE COMMISSIONER

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

RECEIVED
JUL 23 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 07117

217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Derwood
(If outside city or town limits, write RURAL and give nearest town)Street No. Mt. Zion
(If rural, give LOCATION)

2.(a) If veteran, name War

3. (a) FULL NAME

Joshua Dorsey

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Married.6. (b) Name of husband or wife Mary Dorsey

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 18808. AGE: Years Months Days If less than one day
66 2 3 hrs. min.9. Birthplace Montgomery Co. Md.
(Town, county, and state)10. Usual occupation laborer11. Industry or business Farm.12. Name Morton Dorsey13. Birthplace Maryland.14. Maiden name Elizabeth Johnson15. Birthplace Maryland.16. Informant Hospital records

Address

17. Burial Date thereof July 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ZionLocation Montgomery Co. Md.18. Funeral director Ray W. BarberAddress 7-919. 7-9 19. 46 Bertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19. 46 at 11:55 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19. 46 to July 6 19. 46and that I last saw him alive on July 6 19. 46

Immediate cause of death

DURATION

Cerebral Hemorrhage 26 hrsDue to intoxication

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. B. Thompson M. D.Address Sandy Spring, Md. Date signed 7/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 17 1946
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-2

CERTIFICATE OF DEATH

07118

Reg. Dist. No. 223

1. PLACE OF DEATH:

County out county
 City or town Dakota Park Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? nine days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? nine days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Kensington Village
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1120 Midvale Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

GAREY RONALD DWYER.

Baby Dwyer

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) July 13, 1946
 6.(c) If alive, give age years

8. AGE: Years Month Days It less than one day
9 hrs. min.

9. Birthplace Dakota Park Maryland
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name Mr. Elmer Arthur Dwyer
 13. Birthplace Washington DC
 14. Maiden name Marjory Caroline Bowie
 15. Birthplace Pisces Maryland

16. Informant Mrs. Marjory Dwyer
 Address 11120 Midvale Rd. Kensington Md

17. BURIAL Date thereof JULY 29, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FORT LINCOLN

Location PRINCE GEORGES CO MD

18. Funeral director James E. Pumphrey

Address SILVER SPRING MD

19. July 29, 1946
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1946 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7-18-1946 to 7-27-1946
 and that I last saw him alive on 7-27-1946

Immediate cause of death.....

Congenital heart disease -
"Pathology of Fallot"

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other

Address Dakota Park Md Date signed 7-27-46

RECEIVED

AUG 1 1946

BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07119 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution or street address where death occurred:
Washington Sanitarium + Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5712 29th St. Queens Chapel Manor
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Unnamed Infant Evatt

3. (b) Social Security Number

4. Sex Fe 5. Color or race white 6. (a) Single, married, widowed, or divorced —
 6. (b) Name of husband or wife —
 6. (c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) July 24, 1946
 8. AGE: Years Months Days If less than one day
4 hrs. min.

9. Birthplace Takoma Park Md.
 (Town, county, and state)

10. Usual occupation —

11. Industry or business —

12. Name Winston Evatt

13. Birthplace Porterdale, Georgia

14. Maiden name Margaret Bell Seck

15. Birthplace Hyattsville, Md.

16. Informant Washington Sanitarium Records

Address Takoma Park, Md.

17. Burial Date thereof July 29, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Geo. Wash. Memorial Cemetery

Location Piggs Road, P. B. Co., Hyattsville, Md.

18. Funeral director Richard S. Ballou

Address 254 Carroll St., Takoma Park, D.C.

19. Date rec'd by registrar July 29, 46 Registrar J. H. M. Ballou

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28- 19 46 at 5:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-24- 19 46 to 7-28- 19 46 and that I last saw h. els. alive on 7-28- 19 46

Immediate cause of death Intercranial hemorrhage

Due to Traumatic birth injury

Due to Precipitate delivery

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Emma Hughes M.D.

M. D. or other —

Address Takoma Park, Md. Date signed 7-29-46

RECEIVED

AUG 1 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07120

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Mich. County
 City or town Detroit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6458 Auburn Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war [★] ✓

3. (a) FULL NAME

FERRELL, Daniel William, PhM2c v-6 USNR

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 15 July 1925
 8. AGE: Years 20 Months 11 Days 16 If less than one day hrs. min.

9. Birthplace W.Va.
 (Town, county, and state)
 10. Usual occupation Navy
 11. Industry or business
 12. Name Harrison B. Ferrell
 13. Birthplace W.Va.
 14. Maiden name Nova J. Flemming
 15. Birthplace Ind. dec.

16. Informant fa: Mr. Harrison B. Ferrell
 Address 6458 Auburn Avenue, Detroit, Mich.
 17. burial Date thereof 7-3-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Spring Hill
 Location Charleston, W.Va.
 18. Funeral director W. W. Chambers
 Address 1400 Chapin St., N. W. Wash., D.C.
Mary Charlotte Smith
 19. 1 July 19 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 July 19 46 at 2:45P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 June 19 46 to 1 July 19 46
 and that I last saw him alive on 1 July 19 46
 Immediate cause of death Brain Tumor -
right cerebellum and pons
and hemorrhage from tumor
 Due to into subarachnoid space
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations Date of op.
 Autopsy results right cerebellum and pons
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE C. S. Mac CARTHY, Dtl (MC) USN R
Ormac Carty
 Address USNH Bethesda, Md. Date signed 7-1-46

7/9/46

RECEIVED

JUL 10 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07121

Reg. Diat. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. R. 7. D. # 2 Hollywood Park
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

Fincham

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White —

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 19468. AGE: Years Months Days If less than one day
2 hrs. min.9. Birthplace Olney, Montgomery Co. Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name James Ernest Fincham13. Birthplace Nethers, Virginia14. Maiden name Dorothy Agnes Musgrave15. Birthplace Dayton, Maryland16. Informant Hospital records

Address

17. Cremation Date thereof 7-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Montgomery Co. Gen. Hosp. Inc.Location Olney, Md.18. Funeral director Montgomery Co. Gen. Hosp. Inc.Address Olney, Md. F. M. Lischer, Supt.19. 7-20- 19-46 Sexton B. Law
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 46 at 4:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 19 46 to July 20 19 46 and that I last saw him alive on July 20 19 46

Immediate cause of death

Prematurity

DURATION

5 mtsDue to Premature rupture of the membranes - 12 days

Due to

Other conditions (Baby breathed twice but most beat for two hours)
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE JMB M. D. or otherAddress Sandy Spring, Md Date signed 7/20/46

RECEIVED

AUG 14 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

07122

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 hrs +

Hospital, institution, or street address where death occurred:

Suburban Hosp-8600 Old Georgetown Rd.

How long in hospital or institution? 23 hrs + (Bethesda Md.)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7115 Arlington Ave.
(If rural, give LOCATION)

(a) If veteran, name war

3. (a) FULL NAME

Baby/Girl/Fremman

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 7-20-46 - 6¹⁷ P.m. 8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
23 hrs + 23 hrs. 10 min.

9. Birthplace Montgomery Co.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Harold T. Fremman

13. Birthplace Lowell, Mass.

14. Maiden name Muriel Louise

15. Birthplace Washington, D.C.

16. Informant Mr. Harold R. Fremman

Address 7115 Arlington Ave, Bethesda Md.

17. Burial Date thereof 7/22/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Zion Cemetery

Location Bethesda Md.

18. Funeral director W. Kenner Humphrey

Address Bethesda, Md.

19. 7/22/46 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20/46 19 6 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/20/46 19 to 7/24/46 19

and that I last saw h. RR alive on 7/24 19

Immediate cause of death PREMATURITY

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George William Hovey

M. D. or other

Address Suburban Hosp Date signed 7/22/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 24 1946
BUREAU V. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1176

CERTIFICATE OF DEATH

07123

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Suburban Hospital, 8600 Georgetown RoadHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 6317 Prince Georges Ave.
(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Jennie W. Fugitt

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife Mr. Eugene Fugitt

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1865

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>6</u>	<u>15</u>	hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles White13. Birthplace Maryland14. Maiden name Jane Riley15. Birthplace Massachusetts16. Informant Mrs. Virginia Cobson
Address 806 9 St SE, Wash. D.C.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 7/26/46
(month) (day) (year)Cemetery or crematory Wash Nat CemLocation md18. Funeral director W W Chambers CoAddress 577 11th St SE DC19. 7-24-46 (Date rec'd by registrar) Registrar W. E. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1946 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

1946 to 24 July 1946and that I last saw h. ER alive on 24 July 1946Immediate cause of death GENERALIZED PERITONITIS

DURATION

24 hrsDue to PERFORATED DUODENAL24 hrsULCER

Due to.....

Other conditions ARTERIO SCLEROTICUNKNOWNCARDIO VASCULAR DISEASE

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results GENERALIZED PERITONITIS PERFORATEDPHYSICIAN: Please underline the cause to which death should be charged statistically. DUODENAL ULCER

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. E. Jones M.D.

M. D. or other

Address Suburban Hospital Date signed 24 July 1946Bethesda Maryland

RECEIVED

JUL 26 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07124

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick

City or town Thurmont
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

GALL, Henry Lloyd Lt. USN Ret. Inact.

3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 19 Aug 1881 6.(c) If alive, give age _____ years

8. AGE: Years 64 Months 10 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation U.S. Navy Retired

11. Industry or business _____

12. Name Charles Milton Gall (Dec)

13. Birthplace _____

14. Maiden name Mary Jane Warenfeltz (Dec)

15. Birthplace _____

16. Informant Mr. Glenn Gall
 Address Thurmont, Md.

17. burial Date thereof July 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ThurmontLocation Thurmont, Md.18. Funeral director M.L. Creeger and Son

Address Thurmont, Md.
Mary Charlotte Smith

19. 11 July 19 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 July 19 46 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 May 19 46, to 11 July 19 46

and that I last saw him alive on 11 July 19 46

Immediate cause of death

abdominal pathology -
Type undetermined

Due to Parkinson's disease; Duration, 10 years.

Due to Accidental fall - casa

Other conditions Heart & Lung - Corb.
senescence.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident. Date of May 23rd 1946.

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

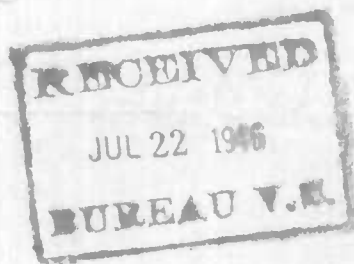
Injured at home, farm, industry, public place (where?) At home.

Means of injury Accidental fall. Injured at work?

23. SIGNATURE J. P. PLATT, Lt. (MC) USN

M. D. or other

Address USNH Bethesda, Md. Date signed 7-11-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

07125

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
 City or town Rock Creek Rockville Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

1004 Lewis Ave. Rock Creek

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.
 City or town Rock Creek Rockville Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1004 Lewis Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Orville Louis Gambin.

3. (b) Social Security Number

577-07-9175

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married -

6. (b) Name of husband or wife

Jennie

7. Birth date of

deceased (mo., day, yr.)

Jan. 2, 19048. (c) If alive, give age 42 years

8. AGE:

Years

Months

Days

If less than one day

4266hrs.min.

9. Birthplace

Brentwood, Md.
(Town, county, and state)

10. Usual occupation

Gas Co.

11. Industry or business

FATHER

12. Name

O. L. Gambin

13. Birthplace

Maryland

MOTHER

14. Maiden name

Secie Snowden

15. Birthplace

Maryland

16. Informant

Mrs. Jennie Gambin

Address

1004 Lewis Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/11/46
(month) (day) (year)

Cemetery or crematory

Rockville Union Cem.

Location

Rockville, Md.

18. Funeral director

Wm. Keuben Pungley

Address

Rockville, Md.

19.

7-91946Josephine D. Wooten
Reg. S. M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 July 19 46 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8 July 19 46 to 8 July 19 46.
 and that I last saw him alive on 8 July 19 46.

Immediate cause of death

Coronary Thrombosis

DURATION

7 hrs.

Due to

unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. S. Murphy M.D.

M. D. or other

Address

Rockville Md.Date signed 9 July 46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUL 11 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female white widow

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

78

6

15

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 46

Wm E Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED
JUL 26 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Montgomery County
City or town... Takoma Park #12, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 min.
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... District of Col. County...
City or town... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4077 Minnesota Ave. N.E. APT.
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Mrs. Emilia Gibson

3. (b) Social Security Number

212-09-6550

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Fidler A. Gibson
7. Birth date of deceased (mo., day, yr.) July 7, 1897 6.(c) If alive, give age... years
8. AGE: Years 49 Months 19 Days 19 It less than one day... hrs. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business own-home
12. Name AUGUST - BECK
13. GERMANY information not obtainable
14. Maiden name ARMENIA - HUBE
15. Birthplace GERMANY

16. Informant Washington Sanitarium and Hospital
Address Takoma Park, #12, Maryland
17. BURIAL Date thereof 7/28/46
(Burial, cremation, or other) (month) (day) (year)
Cemetery or crematory BALTIMORE
Location BALTIMORE - MD.
18. Funeral director St. Clements
Address 517-11 St.
19. July 27, 1946
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 7-26 19 46 at 8:30 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10, 1945 to Feb. 26, 1946
and that I last saw him alive on July 8, 1946
Immediate cause of death... Hemorrhage + shock DURATION 24 hr.
Due to Generalized Atherosclerosis
Due to Carcinomatosis
Other conditions...
(Include pregnancy within 3 months of death)
Major findings of operations Cancer of sigmoid - Rectum - lined with carcinoma Date of op. Feb 1945
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?
23. SIGNATURE Paul E. Janet MD M. D. or other
Address 4847-ILL. AVE Date signed 7-26-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07128

Reg. Diat. No. 214

1. PLACE OF DEATH

County MontgomeryCity or town Ladonia Park Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 daysHospital, institution, or street address where death occurred:
805 Maple AveHow long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 509-M-18th
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BELLE (Miller) Green

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed.8. (b) Name of husband or wife Charles E.7. Birth date of deceased (mo., day, yr.) 1858
6. (c) If alive, give age years8. AGE: Years 88 Months Days If less than one day
hrs. min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation H-wife

11. Industry or business

12. Name Louis Miller13. Birthplace Va.14. Maiden name ? Young15. Birthplace Va.16. Informant William S. GreenAddress 509-M-18th S.W.17. Burial Date thereof Aug. 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Prince Geo. Co. Md.18. Funeral director W. W. Chambers Co.Address Wash., D.C.19. July 30 19 46 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 46 at 7:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 45 to July 31 19 46and that I last saw him alive on July 27 19 46Immediate cause of death Congestive failureDURATION 2 weeksDue to hypertensive cardiac disease

unknown

Due to Coronary artery disease

several months

Other conditions with infection

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

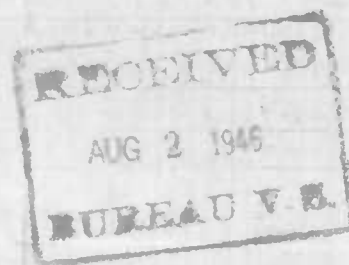
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry G. SpillerAddress 1252 4th St Date signed Aug 30 19 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07129

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, (Md.)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia

County

City or town Clarksburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Duff St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Joe Rogers GRIFFIN Comdr (DC) USNR Act.

3.(b) Social Security Number

4. Sex

male

5. Color or race

W-US

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Mary V. Griffin

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

9-25-03

8. AGE:

Years

Months

Days

If less than one day

42103

hrs.

min.

9. Birthplace West Virginia

(Town, county, and state)

10. Usual occupation U.S. Navy (dentist)

11. Industry or business

FATHER
MOTHER12. Name Lloyd Griffin13. Birthplace W. Va.14. Maiden name Alberta Rogers15. Birthplace W. Va.16. Informant Mrs. Mary V. GriffinAddress 110 Duff St. Clarksburg, W. Va.17. burial Date thereof 7-30-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sunset MemorialLocation Clarksburg, W. Va.18. Funeral director W.W. CHAMBERS CO. W.W.C.Address 1400 Chapin St. N.W. Wash., D.C.19. 7-28-46
(Date rec'd by registrar)

19

Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 July 1946 at 8:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 April1946

to

28 July1946and that I last saw him alive on 28 July1946

Immediate cause of death

DURATION

Due to

Uremia
Hypertensive heart disease10 days
six months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. E. SHAFER, Comdr. (MC) USN

M. D. or other

Address

USNH Bethesda, Md.

Date signed

7-28-46

RECEIVED

AUG 5 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07130 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 9300 Georgia Ave.
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

Mary E. Hollowell

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Millard Hollowell

7. Birth date of deceased (mo., day, yr.)

June 16, 1865

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8115

hrs.

min.

9. Birthplace

Belfast, Maine
(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

FATHER

12. Name

Frank Wyley

13. Birthplace

Belfast, Maine

MOTHER

14. Maiden name

?

15. Birthplace

Maine

16. Informant

Nephew, Dr. Carroll Reed

Address

9300 Georgia Ave, Silver Spring

17. BURIAL & TRANSPORTATION: (Burial, cremation, or removal. Which?)

Date thereof JULY 21 - 1946
(month) (day) (year)

Cemetery or crematory

ST. PAUL - RAMSEY Co - MINN.

Location

18. Funeral director

Edgar & Humphrey

Address

SILVER SPRING - MD.

19.

7/231946Wm E. Jones

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 46 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 30 19 46 to July 21 19 46and that I last saw him alive on July 20 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

21 days

Due to

Due to

Other conditions

Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

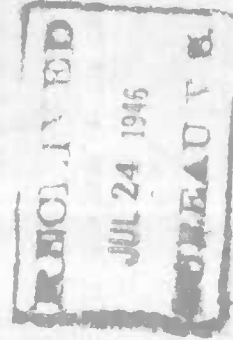
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Marion Bauschard MD
9601 Sutton place M. D. or other
Silver Spring, MD Date signed 7/21/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07131

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months & 25 days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months & 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State County
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2400 16th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war [star] ✓

3. (a) FULL NAME

HATCH, Charles Byron, Captain USNR Retired

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Mabel D. Hatch
7. Birth date of deceased (mo., day, yr.) 20 August 1878
8. AGE: Years 67 Months 10 Days 12 If less than one day hrs. min.

9. Birthplace Ill.
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business

12. Name Charles B. Hatch

13. Birthplace N.Y. (dec)

14. Maiden name Martha Hodgen

15. Birthplace Ky. (dec)

16. Informant wife: Mrs. Mabel D. Hatch

Address 2400 16th St., N.W., Wash., D.C.

17. burial Date thereof 7-5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. Chambers

Address 1400 Chapin St., N.W., Wash., D.C.

19. 3 July 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 July 19 46 at 7:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 April 19 46 to 2 July 19 46
and that I last saw him alive on 2 July 19 46

Immediate cause of death Hypertension Rt
with & without Metastasis DURATION 1+ yr.

Due to

Due to

Other conditions Nephritis DURATION 3 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Hypertension Rt. with metastasis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (Where?)

Means of Injury Injured at work?

23. SIGNATURE H. B. COCKLEY, Captain (MC) USN

M.D. or other

Address USNH Bethesda, Md. Date signed 7-3-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/15/46

RECEIVED
JUL 16 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-8

07132

CERTIFICATE OF DEATH

Reg. Dist. No. 514

1. PLACE OF DEATH:

County Montgomery
 City or town Rural - Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Rural - Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. #2 - Colesville Pike.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles Hopkins

3. (b) Social Security Number

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) April ? 1867 6. (c) If alive, give age _____ years

8. AGE: Years 79 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Rural - Silver Spring, Montgomery County, Md.

10. Usual occupation farmer

11. Industry or business _____

12. Name Joseph Hopkins

13. Birthplace Maryland

14. Maiden name Mary V. Cooper

15. Birthplace Maryland

16. Informant Eugene Hopkins, Bro.

Address R.F.D. #2 Silver Spring, Md.

17. Burial Date thereof July 5th 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns - Forest Glen, Md.

Location _____

18. Funeral director James E. Humphrey

Address 8434 Ga Ave - Silver Spring - Md.

19. July 19 46

(Date rec'd by registrar) Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 July 19 46 at 10⁰⁰ p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 June 19 46 to 30 June 19 46 and that I last saw him alive on 30 June 19 46

Immediate cause of death Asthma, severe DURATION 3 mo.

Due to Senility

Due to Carcinoma of the stomach, excised

Other conditions Duration: Unknown

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Helmer J. Brown M.D.

Address 45 Carroll Ave Date signed 2 July 46

Takoma Park

RECEIVED

JUL 10 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

07133

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... Arlington, Va.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 2327 S. Nash St.
 (If rural, give LOCATION)

2.(a) Is veteran, name war...

3. (a) FULL NAME

Theodore HUBER

3. (b) Social Security Number

4. Sex... male
 5. Color or race... W-US
 6.(a) Single, married, widowed, or divorced... married

6.(b) Name of husband or wife... Edith M. Huber
 6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)... 14 November 1859

8. AGE: Years... 86 Months... 8 Days... 13
 If less than one day... hrs. min.

9. Birthplace... Mo.
 (Town, county, and state)

10. Usual occupation... Retired Navy personnel

11. Industry or business

12. Name... John Huber (dec.)13. Birthplace... unknown14. Maiden name... Josephine Wang (dec.)15. Birthplace... unknown16. Informant... Mrs. Edith M. HuberAddress... 2327 S. Nash St. Arlington, Va.

17. burial Date thereof... 7-30-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington NationalLocation... Arlington, Virginia18. Funeral director... W. W. CHAMBERS CO. W. W. C.Address... 1400 Chapin St. N.W. Wash. D.C.

19. 28 July 1946
 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 27 July 1946 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
30 March 1944 to 27 July 1946
 and that I last saw him alive on 27 July 1946

Immediate cause of death... hypostatic pneumonia
 DURATION... 3 days

Due to... cerebral vascular accident DURATION... 7 days

Due to... Papier's disease DURATION... 5 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

J. C. DUNN, Comdr. (MC) USN

23. SIGNATURE

USNH Bethesda, Md. M. D. or other 7-28-46
 Address... Date signed

RECEIVED

AUG 5 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07134

Reg. Diat. No. 223

1. PLACE OF DEATH:

County... Montgomery County
 City or town... Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 2 days 6 1/2 hrs.
 Hospital, institution, or street address where death occurred:
Washington San. and Hospital, Takoma Park, MD
 How long in hospital or institution?... 2 days 6 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... District of Col. County...
 City or town... Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 9-5th St. N.E. Washington, D.C.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Hutchinson, Mr. Albert B.3. (b) Social Security Number
579-20-3813

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife... NONE

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) May 20, 18878. AGE: Years Months Days If less than one day
59 1 28 ...hrs. ...min.9. Birthplace... Washington, D.C.
(Town, county, and state)10. Usual occupation... tool - maker11. Industry or business... own - home shop12. Name... John A. Hutchinson13. Birthplace... Washington, D.C.14. Maiden name... Lacelia Smith15. Birthplace... Ellicott City, Maryland16. Informant... Washington San. and Hospital RecordsAddress... Takoma Park, Maryland17. Burial Date thereof... July 22 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Congressville CemeteryLocation... Washington, D.C.18. Funeral director... W. William Lee's SonsAddress... 300 - 4 St NE19. July 19 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 18 19 46 at 8 ²⁷ p. M21. I CERTIFY that death occurred on the data above stated; that I attended deceased from July 16 19 46 to July 18 19 46 and that I last saw him alive on July 18 19 46Immediate cause of death... ① Bronchopneumonia and pulmonary edema

DURATION

1 day

② Uremia

2 weeksDue to... Carcinoma head of the pancreas with widespread metastasesunknown

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... SameDate of op. July 18 - 1946 autopsy results... Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Blumen J Brown MD M. D. or otherAddress... 45 Carroll Ave Tak. Park Date signed... July 19 - 1946

RECEIVED

JUL 22 1946

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07135

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
City or town Clagettsville MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Clagettsville MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2. (a) If veteran, name war. No

3. (a) FULL NAME

Towney H. Hyatt

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Annabell Hyatt
6. (c) If alive, give age 0 years
7. Birth date of deceased (mo., day, yr.) Aug 1 - 1874
8. AGE: Years 72 Months 11 Days 18 If less than one day hrs. min.

9. Birthplace Frederick CO
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business Farm
12. Name Thomas H. Hyatt
13. Birthplace Montgomery CO.
14. Maiden name Alcinda Moxley
15. Birthplace Montgomery CO.

16. Informant Mr. A. A. Moxley
Address Clagettsville MD.
17. Burial Date thereof July 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Montgomery
Clagettsville MD.
Location Roy W. Barber
18. Funeral director Laytonsville MD.
Address July 30 1946 Della K. Barber
19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1946 at 4:15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21, 1945 to July 28, 1946
and that I last saw him alive on July 11, 1946
Immediate cause of death Arteriosclerotic cardio-vascular disease
DURATION 10 years

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Windsor, Md. Date signed 7/29/46

MARGIN RESERVED FOR BINDING

VS A15 9445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 1 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07136

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Pennsington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Pennsington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Millie Jackson

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 18928. AGE: Years 54 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Derwood, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Adams13. Birthplace Watts, Maryland14. Maiden name Caroline Hood15. Birthplace Watts, Maryland16. Informant William Jackson (son)Address Pennsington, Md.17. Buried Date thereof July 20 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Good HopeLocation Collesville, Md.18. Funeral director Robert L. SnowdenAddress 246 N. Wash. St Rockville19. July 19 1946 Jacques M. Phaff
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1946, at 11 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1946 to July 17 1946
and that I last saw her alive on July 14 1946Immediate cause of death Cerebral Occlusion DURATION 5/15/46

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. ?

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Calvin B. LeCompte M. D. or other _____Address Wheaton, Md. Date signed ?

RECEIVED
JUL 23 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

07137

Reg. Dist. No. 213

1. PLACE OF DEATH:

County... Montg

City or town... Potomac Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

48 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Montg

City or town... Potomac
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Samuel Jackson

3. (b) Social Security Number

4. Sex Male 5. Color or race colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 25 - 1872

8. AGE: Years 73 Months Days If less than one day hrs. min.

9. Birthplace Va
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Temple Jackson

13. Birthplace Va

14. Maiden name unknown

15. Birthplace Va

16. Informant Lottie Steward

Address 2455 P St N.W. Wash

17. Burial Date thereof July 13 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director W Ernest Jarvis Co

Address 1432 Eye St N.W.

19. 7-13-46 Betty Jane Smith
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1946 at 2:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 11 1946 to July 13 1946
and that I last saw him alive on July 11 1946

Immediate cause of death Acute dilatation of heart

Due to Sudden death

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. J. Hatcher M.D.

Address Rockville Md Date signed 7/13/46

RECEIVED
JUL 16 1946
BUREAU V. B.

Telephone call to undertakers - gave the
Following information: -

Burial - July 17, 1946

Mt. Glory Cemetery

Brickyard, Md.

Betty Jane Snyder

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 108 Days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 108 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Va. County Falls Church
City or town Falls Church
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111
(If rural, give LOCATION)
2. (a) If veteran, name war 111 ✓

3. (a) FULL NAME

Ewald Carl KILLINGER V.B.P.

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) December 3, 1890 6. (c) If alive, give age _____ years
8. AGE: Years 55 Months 7 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual occupation Veteran
11. Industry or business _____
12. Name George William Killinger (dec.)
13. Birthplace Indiana
14. Maiden name Mary Jane Ewald (dec.)
15. Birthplace Indiana

16. Informant Marie K. Nigh
Address Falls Church, Va.
17. burial Date thereof 7-16-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.
18. Funeral director Jos Gawler Co.
Address 1754 Penna Ave. N.W. Wash., D.C.
19. 13 July 1946
(Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 July 1946 at 12 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 March 1946 to 13 July 1946
and that I last saw him alive on 13 July 1946

Immediate cause of death Diabetes mellitus DURATION 5 yrs.
Due to _____
Due to _____
Other conditions gen. ext. atherosclerosis
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results prostatic fibrosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Charles W. Thompson MD M. D. or other _____
Address 1111 Falls Church Ind Date signed 7.16.46

MARGIN RESERVED FOR BINDING

VS A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/19/46

RECEIVED

JUL 22 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12-2

CERTIFICATE OF DEATH

07139

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Takoma Park, Md.
 City or town... Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days - 10 1/2 hrs.
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 5 days - 10 hrs - 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 337 Webster St. N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... ☒

3. (a) FULL NAME

Miss Annie Kilmartin

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Cauc. Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 26, 18738. AGE: Years Months Days It less than one day
72 7 7 hrs. min.9. Birthplace... Washington, D.C.
 (Town, county, and state)10. Usual occupation... Retired govt. clerk.

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant... Records - Washington San. Hosp.Address... Takoma Park, Md.17. Removal Burial Date thereof 7/8/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Washington National CemeteryLocation... Washington, D.C. City of Va.18. Funeral director... J. H. Niles Co.Address... 4401 14th St. N.W.19. July 3 1946 J. H. Niles
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 3 1946 at Home

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1945 1945 to 1946and that I last saw him... alive on July 3, 1946

Immediate cause of death

Fracture of ribs (rt.) with
hemorrhage in pleural cavity
(accidental)Due to... accidental

Due to...

Other conditions... Cardiac Hypertrophywith sclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. 7-3-46Autopsy results... same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... accident Date of 7-3-46Where did injury occur? Takoma Park, Md.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Takoma Park, Md.

Means of injury Injured at work?

23. SIGNATURE... Frank J. Brochard M.D.Address... Washington, D.C. Date signed 7-3-46

RECEIVED

JUL 9 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. 1. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 11 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4951 Blaine St., N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

KING, Bulah (n)

3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 10, 1897

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

48

7

21

hrs.

min.

9. Birthplace

S.C.

(Town, county, and state)

10. Usual occupation

veteran

11. Industry or business

FATHER

12. Name Allan King13. Birthplace SC dec.

MOTHER

14. Maiden name Mary ?15. Birthplace SC dec16. Informant daughter: Miss Mary KingAddress 4951 Blaine St., N.E., Wash., D.C.17. burialDate thereof 8-3-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. Ernest W. Jarvis W. R. SmithAddress 1432 U St., N. W., Wash., D.C.19. July 31 46 Mary Charlotte Smith

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 July 19 46 at 5:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 June19 46to 31 July19 46and that I last saw him alive on 31 July19 46

Immediate cause of death

DURATION

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. S. ASHBURN, Lt. Cdr. (MC) USN

M. D. or other

Address USNH Bethesda, Md.Date signed 7-31-46

RECEIVED
AUG 9 1946
BUREAU U.S.

File as Death

(159)

07140

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 138

A certificate must be filed within 24 hours for every still birth of 20 weeks gestation or more (see stub)

1. PLACE OF BIRTH: Montgomery
County Frederick
City or town Lewisdale (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
Length of mother's stay in County 1. Feb 26 yrs
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
State Maryland
County Frederick Montgomery
City or town Lewisdale (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Post Office - Monrovia
(If RURAL give LOCATION)

3. Name of child Not Named
5. Sex Female 6. Twin or triplet

4. Date of birth July 25 1946 Hour 6:30 P. M.
7. No. of weeks pregnancy 23

FATHER OF CHILD
8. Full name Earl Virginia King
9. Color W 10. Age at time of this birth 42 yrs.
11. Usual occupation Farmer

MOTHER OF CHILD Brown
12. Full maiden name Mildred Francis King
13. Color W 14. Age at time of this birth 26 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 5
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

18. Pregnancy, complications of Bleeding 1 month before delivery

(a) Fetal causes Undetermined

19. Labor: (a) Complications of None
(b) Induced? No

(b) Maternal causes Undetermined, Premature

20. (a) Was there an operation for delivery? No
(b) State all operations, if any

22. I certify to the birth of this child who was born dead* on the date and hour above stated. (see margin)

(c) Did child die before operation?
During operation?

Signature Dorothy Ross, M.D.
(Specify if M. D., midwife, or other)

23. (a) Burial (b) Date thereof July 26, 1946
(Burial, cremation or removal) (month) (day) (year)

Address New Market, Md.

(c) Cemetery or crematory On farm

25. (a) July 26-46 L. H. Salem
(Date rec'd by registrar) (Registrar)

24. (a) Funeral director None
(b) Address

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

child lived about 50 minutes

V. S. A10

RECEIVED
AUG 8 1945
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B7C)

CERTIFICATE OF DEATH

07142

Reg. Dist. No. 211

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Woodfield
(If outside city or town limits, write RURAL and give nearest town)Street No. R. T. D. Gaithersburg
(If rural, give LOCATION)2. (a) If veteran, name war No

3. (a) FULL NAME

James Rufus King

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed8. (b) Name of husband or wife Della Woodfield KingDeceased April 1945

7. Birth date of

May

6. (c) If alive, give age

131871

8. AGE:

Years

75

Months

2

Days

10

If less than one day

hrs.min.9. Birthplace Woodfield, Montgomery Co., Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Dairy & General Farming

FATHER

12. Name

Singleton King

13. Birthplace

Woodfield, Maryland

MOTHER

14. Maiden name

Mary Burdette

15. Birthplace

Montgomery County, Maryland

16. Informant

John L. King

Address

Gaithersburg Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 26 1946

(month) (day) (year)

Cemetery or crematory

Wesley Grove Cemetery

Location

Woodfield, Maryland

18. Funeral director

J. B. Beall INC

Address

Damascus, Maryland

19.

July 25 46

(Date rec'd by registrar)

Della O. Burdette

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1946 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January1939to July 23, 1946and that I last saw him alive on July 23, 1946Immediate cause of death Acute Dilatation of the Heart.

DURATION

Due to Generalized Arteriosclerosis 10 yrs
& C-V-R disease.Due to Cerebral Arterial Thrombosis 1 yr
Hypertrophy of the ProstateOther conditions Gland ?(with urethral obstruction) 1 week

(Include pregnancy within 3 months of death)

Major findings of operations Transurethral Prostatectomy
(tissue sent for lab exam) Date of op. July 22Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Wm. H. Anderson Boyer M.D.Address Damascus, Maryland, Date signed July 24

1946

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 88-2

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Fernwood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Fernwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 102 Fernwood Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

CLAUD LIVINGSTON Sr.

3. (b) Social Security Number

578-01-6681

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married.

6. (b) Name of husband or wife Almira Trew Livingston8. (c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) Jan 4. 1879

8. AGE: Years Months Days If less than one day

67 5 11 hrs. min.

9. Birthplace Harris Co. Georgia

(Town, county, and state)

10. Usual occupation Realtor (President)11. Industry or business Wm. E. Livingston Co.12. Name James R. Livingston13. Birthplace Fla.14. Maiden name Saula F. Jones15. Birthplace Fla.16. Informant Mrs. Almira S. MillbAddress 1622-44th St. N.W. D.C.17. Burial Date thereof July 17-46

(Burial, cremation, or removal, Which?) (Month) (day) (year)

Cemetery or crematory Rock Creek Cem. Wash. D.C.Location S. H. Hines Co.18. Funeral director S. H. Hines Co.Address 2901-14th St. N.W. D.C.19. 7/15 19 46 Wm E Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 46, at 1:15 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 19 46 to July 15 19 46and that I last saw him alive on July 15 19 46Immediate cause of death Cerebral hemorrhage DURATION 3 daysDue to Cerebral arterio sclerosis 2 to 3 yearsDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —23. SIGNATURE R. Lyman Sexton M.D.Address 1801 Eye St. N.W. Date signed July 15Wash. D.C.

140

MARYLAND STATE DEPARTMENT OF HEALTH

OFFICE OF VETERINARY MEDICINE

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

RECEIVED

JUL 17 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
4628 Rosedale Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4628 Rosedale Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

Clarence Oliver Luhn 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

6. (b) Name of husband or wife Inez Luhn6. (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) June 2, 1893

8. AGE: Years 53 Months 1 Days 4 If less than one day
hrs.min.

9. Birthplace Maryland
 (Town, county, and state)10. Usual occupation Dept. Commerce

11. Industry or business

12. Name Randolph Luhn13. Birthplace Maryland14. Maiden name Price15. Birthplace Maryland16. Informant Mrs. Inez LuhnAddress 4628 Rosedale Ave. Bethesda, Md17. Burial Date thereof July 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National Cem.Location Arlington, Va.18. Funeral director Wm Reuben HumphreyAddress 7557 Wis. Ave. Bethesda, Md.19. 7/9 19 46 Wm E Jones
 (Date rec'd by registrar) Registrar20. DATE OF DEATH 7/6/46 19 46, at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. Med. Exam case 19..... to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death Coronary occlusion
diad
suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Broschart M.D. M. D. or otherAddress Ch. Shering Ind. Date signed 7-6-46

RECEIVED
JUL 15 1946
BUREAU V. G.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

07153
Reg. Diat. No. 216

1. PLACE OF DEATH:
County... Montgomery
City or town... Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?..... Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Montgomery
City or town... Cabin John, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
WILLIAM JAMES MALONE

3. (b) Social Security Number
579-09-9027

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife... Minnie Irene Malone
8. (c) If alive, give age... 43 years
7. Birth date of deceased (mo., day, yr.) Jan. 13, 1903

8. AGE: Years <u>43</u>	Months <u>6</u>	Days <u>22</u>	If less than one dayhrs.min.
----------------------------	--------------------	-------------------	--

9. Birthplace... Washington, D. C.
(Town, county, and state)
10. Usual occupation... Police Officer- Montg. Co.
11. Industry or business

FATHER	12. Name... <u>William J. Malone</u>
	13. Birthplace... <u>Unknown</u>
	14. Maiden name... <u>Unknown</u>
MOTHER	15. Birthplace... <u>Unknown</u>

16. Informant... Mrs. Minnie I. Malone
8th St. Cabin John, Maryland
Address

17. Burial Date thereof... 7/28/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory... Potomac Church Cemetery
Potomac, Maryland
Location

18. Funeral director... Wm. E. Jones
Address... 7557 Wis. Ave. Bethesda, Maryland

19. 7/26 19 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 25 19 46, at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 1945 Exam Case 19... to 19...
and that I last saw him... alive on ... 19...

Immediate cause of death	DURATION
<u>Coronary occlusion</u>	<u>divid</u>
Due to...	<u>subd</u>
Due to...	
Other conditions	

(Include pregnancy within 8 months of death)
Major findings of operations..... Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE... Frank J. Broschart M.D.
Dep. Med. Exam M. D. or other
Address... Washington, Md Date signed... 7-25-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAINS OF THE WINDY STATE CHAIRMAN

REMAINS OF THE WINDY STATE CHAIRMAN



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

07145

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State Ind County Prince George
City or town Accokeek
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Julia Walton Manning

3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed
(b) Name of husband or wife Robert Lee Manning
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 11, 1869
8. AGE: Years 77 Months 4 Days 37 If less than one day hrs. min.

9. Birthplace College View Prince George. Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

12. Name Joseph C Walton
13. Birthplace Prince George County Ind.
14. Maiden name Caroline Louise Steele
15. Birthplace Hamlet, Va

16. Informant Mrs Harold Gatis
Address 7205 - 8th Ave. Wash. D.C

17. Burial Date thereof July 10, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Christ Church Cemetery
Location Accokeek, Md. Prince George Co.

18. Funeral director Arthur H. Hays
Address 254 Carroll St. Takoma Park, D.C.

19. July 8 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 8 19 46 at 8:10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 46 to July 8 19 46
and that I last saw him alive on 7/7/46

Immediate cause of death Broncho pneumonia
DURATION 7/6/46

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Home
M. D. or other
Address 28 Carroll Ave Date signed 7/8/46

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
JUL 9 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

07146

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since May 19, 1946

Hospital, institution, or street address where death occurred:

How long in hospital or institution? since May 19, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va County ArlingtonCity or town Arlington
(If outside city or town limits, write RURAL and give nearest town)Street No. 4267 Vacation Lane
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Maynard, Harriet Hatton

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W6. (b) Name of husband or wife Robert P. Maynard

7. Birth date of

deceased (mo., day, yr.)

Nov 14, 1860

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8580hrs.min.

9. Birthplace

 Dublin, Ireland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Thomas J. Hatton

13. Birthplace

Dublin Ireland

MOTHER

14. Maiden name

Mary Webster

15. Birthplace

New York state

16. Informant

Mrs. Morton Macartney

Address

4267 Vacation Lane, Arlington Va

17.

(Burial, cremation, or other disposition)

Date thereof

July 16, 46
(month) (day) (year)

Cemetery or crematory

Prince Georges Co. Washington D.C. Maryland

18. Funeral director

Joseph Sawyers Sons

Address

1756 Pa. Ave. N.W. Wash. D.C.

19.

(Date rec'd by registrar)

19

46J. Wilson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 14469:15pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2346

to

July 1446

and that I last saw her alive on

July 1446

Immediate cause of death

Bronchopneumonia

DURATION

3 day

Due to

Arteriosclerosis, cerebralunknown

Due to

Senilityunknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William J. Brown

M. D. or other

Address

40 Carroll Ave. TakomaDate signed July 14, 46

RECEIVED

JUL 16 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

07147

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mon. 17 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 mon. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Charles
 City or town Indianhead
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) [*] ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

McGINNIS, Henry James

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Mrs. Margaret M. McGinnis
 7. Birth date of deceased (mo., day, yr.) Nov. 14, 1888 6.(c) If alive, give age _____ years
 8. AGE: Years 57 Months 8 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Mass. (Town, county, and state)
 10. Usual occupation Veteran
 11. Industry or business _____
 12. Name James E. McGinnis
 13. Birthplace Mass.
 14. Maiden name Helena Keith
 15. Birthplace Mass. dec.

16. Informant wife: Mrs. Margaret M. McGinnis
 Address Indianhead, Md.
 17. burial Date thereof 8-1-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director Hunt & Ryon M.T.F.
 Address Waldorf, Md.
7-30 46 Mary Charlotte Smith
 19. (Date rec'd by registrar) 19 _____ Registrar Mary Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 July 19 46 at 5:35P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 June 19 46 to 29 July 19 46
 and that I last saw him alive on July 29 19 46
 Immediate cause of death Thrombosis coronary artery DURATION 10 min.
 Due to coronary artery sclerosis years _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results as above + myocardial fibrosis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury Gun Thompson Injured at work? _____
 23. SIGNATURE C. W. THOMPSON, Lt.Cdr.(MC) USNR
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 7-30-46

8/31/46

RECEIVED
AUG 5 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**
of deceased is shown on 2411 N. Charles St., Baltimore *92-a*

FILM No. **I 06 AUG 2 - 1946**

CERTIFICATE OF DEATH

Reg. Dist. No. *218*

1. PLACE OF DEATH:

County *Montgomery*

City or town *Gaithersburg, Maryland*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *35 Years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Montgomery*

City or town *Gaithersburg*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *Southern Suburb*
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

MRS. MARY GRAVES MCGRAW

3. (b) Social Security Number

770

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife *Fred M. McGraw*

6. (c) If alive, give age *77* years

7. Birth date of deceased (mo., day, yr.) *August 14, 1874*

8. AGE:

Years *72*

Months *71*

Days *11*

If less than one day *10*

hrs.

min.

9. Birthplace *Virginia*

(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *Willard Graves*

13. Birthplace *Wisconsin*

14. Maiden name *Lucy Libby*

15. Birthplace *New Hampshire*

16. Informant *Mr. Fred M. McGraw*

Gaithersburg, Maryland

Address

17. *Burial* Date thereof *7/27/46*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Darnestown Church Cem.*

Darnestown, Maryland

Location

18. Funeral director *Wm. Robert Thompson*

Address *7557 Wisconsin Ave. Bethesda, Md.*

19. *July 26* 19*46* *Charles E. Cooke*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 24* 19*46* at *1:30 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1928*

and that I last saw him alive on *July 24* 19*46*

Immediate cause of death *Acute coronary thrombosis*

DURATION

Last months

Due to *Arterial sclerosis* *20 yrs*

Due to *Heart block* *?*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address *Norton D. Thomas M.D.* Date signed *7/28/46*

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REC-70
JUL 29 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *52a*

CERTIFICATE OF DEATH

07149

Reg. Dist. No. *223*

1. PLACE OF DEATH:

County *Montgomery County*City or town *Takoma Park, Maryland*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *44 days*

Hospital, institution, or street address where death occurred:

*Washington Sanitarium and Hospital*How long in hospital or institution? *44 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Dist. of Col* CountyCity or town *Washington, D.C.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *6500 Utah Ave. Wash. D.C.*
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Catherine M^c Grew

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

*Married*6. (b) Name of husband or wife *Mr. John L. McGrew*7. Birth date of deceased (mo., day, yr.) *March 6, 1883*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*63**4**18*

hrs.

min.

9. Birthplace

Fauquier, Virginia
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

own home

MOTHER FATHER

12. Name

13. Birthplace

information not available

14. Maiden name

15. Birthplace

16. Informant

Washington San. and Hospital Records

Address

Takoma Park, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 27, 1946
(month) (day) (year)

Cemetery or crematory

Warrenton Cem.

Location

Warrenton, Va.

18. Funeral director

S. J. Hines Co.

Address

2901 - 14th St. N.W. Washington, D.C.

19. July 25, 1946

(Date registered by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 24, 1946* at *6:03 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1946 to *July 24, 1946*and that I last saw him alive on *July 24, 1946*

Immediate cause of death

Carcinoma of lungs & Pleura

DURATION

9 mos

Due to

*Carcinoma of R. Kidney**?*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results *Conforms above*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert A. Hare M.D.

M. D. or other

Address

Takoma Park, Md.

Date signed

7/24/46

RECEIVED
JUL 27 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

07150

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF BIRTH:

County Montgomery
 City or town Kensington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of birth? 33 years
 Hospital, institution, or street address where death occurred:
17 Montgomery Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Kensington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 17 Montgomery Ave.
 (If rural, give LOCATION) [★]
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

Porter F. McKeever

3. (b) Social Security Number

No

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
 6. (b) Name of husband or wife Divorced
 7. Birth date of deceased (mo., day, yr.) Jan. 16, 1897 8. (c) If alive, give age _____ years
 8. AGE: Years 49 Months 5 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Lonaconing, Maryland
 (Town, county, and state)
 10. Usual occupation Ice Cream Manufacturer
 11. Industry or business Ice Cream Plant
 12. Name Albert F. McKeever
 13. Birthplace Washington, D. C.
 14. Maiden name Julia Orr
 15. Birthplace Lonaconing, Maryland

16. Informant Mrs. Willard A. Warthen
 Address 3 W. Everett St. Kensington, Md.

17. Burial 7/14/46
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Rockville Union Cem.
 Location Rockville, Maryland

18. Funeral director W. Reuben Humphrey
 Address 7557 Wis. Ave. Bethesda, Md.

19. 7/13 46 7m E. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1946 11:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1946 to July 11, 1946and that I last saw him alive on Exam. Camp 1946Immediate cause of death Cornary occlusion

DURATION

Found dead in home

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Broschart M.D. M. D. or otherAddress Washington, Md. Date signed 7-12-46

RECEIVED
JUL 16 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07151

Reg. Dist. No. 214

1. PLACE OF DEATH

County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9108 Wire Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9108 Wire Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MINA GERTRUDE MILLER

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife Harry Davidson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 19th. 1866

8. AGE:

Years

Months

Days

If less than one day

79

6

19

hrs.

min.

9. Birthplace Marion, Iowa

(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business Own Home

12. Name Jacob Booze

13. Birthplace Ohio

14. Maiden name Elizabeth Brown

15. Birthplace Ohio

16. Informant Mrs. Richard E. Schneder

Address 9108 Wire Avenue, Silver Spring, Md

17. REMOVAL & BURIAL Date thereof JULY 10 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory JEWELL

Location JEWELL JEWELL CO KANSAS

18. Funeral director Warner & Humphrey

Address SILVER SPRING MD

19. July 10 46 Josephine Schaeffe
(Date rec'd by registrar) (Regist.)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8th 1946 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945 to July 8 1946

and that I last saw her alive on July 8 1946

Immediate cause of death

CORONARY THROMBOSIS

DURATION

1 wk.

Due to arterio sclerosis

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul W. Taylor M.D.

M. D. or other

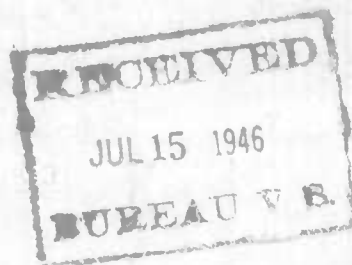
Address 2140 Penna Ave Date signed 7-8-46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (157-2)
CERTIFICATE OF DEATH

07152
Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Washington, D.C. County D.C.
(If outside city or town limits, write RURAL and give nearest town)
City or town Washington, D.C.
Street No. 3990 Langley Court, N.W.
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME MILLMAN, Chester John
3. (b) Social Security Number

4. Sex male
5. Color or race W-US
6. (a) Single, married, widowed, or divorced infant

6. (b) Name of husband or wife
6. (c) If alive, give age 12 July years

7. Birth date of deceased (mo., day, yr.) July 12, 1946

8. AGE: Years 0 Months 0 Days 5 It less than one day hrs. min.

9. Birthplace Bethesda, Md.
(Town, county, and state)

10. Usual occupation infant

11. Industry or business

12. Name Chester John MILLMAN
13. Birthplace Ky.

14. Maiden name Ruth Virginia CRANDALL
15. Birthplace Pa.

16. Informant Father: Chester John Millman
Address 3990 Langley Court, N.W., Wash., D.C.

17. burial Date thereof 7-18-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory George Washington Memorial
Location Hyattsville, Md.

18. Funeral director W. W. CHAMBERS
Address 1400 Chapin St., N.W., Wash., D.C.

19. 18 July 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 July 1946 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 July 1946 to 17 July 1946
and that I last saw him alive on 17 July 1946

Immediate cause of death Infarct, pulmonary
DURATION 2

Due to Endocarditis 5hr
Coarctation aorta 5hr
Due to Pylosic stenosis 5hr

Other conditions Hematuria (2-3 weeks)

(Include pregnancy within 3 months of death)
Major findings of operations Pylosic stenosis

infant limb. Patent foramen ovale, vegetation
Autopsy results recent valve, plaque aorta, 2-3 weeks
PHYSICIAN: Please underline the cause to which death should be charged recently occurred

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Paul Peterson Injured at work?

23. SIGNATURE PAUL PETERSON, Captain (MC) USN
Address USNH Bethesda, Md. M. D. or other 7-18-46
Date signed

RECEIVED
JUL 24 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

07154

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Glen Echo Hyts.
(If outside city or town limits, write RURAL and give nearest town)Street No. 6406 Madawaska Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Ethel Moore

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single8. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) August 30, 1875

8. (c) If alive, give age years

8. AGE: Years 70 Months 10 Days 7 If less than one day
.....hrs.min.9. Birthplace Elkton, Tenn.
(Town, county, and state)10. Usual occupation Teacher, Private School
Retired

11. Industry or business

12. Name Asa Winfrey Moore
Tenn.

13. Birthplace

14. Maiden name Eva Bull15. Birthplace Elkton, Tenn.16. Informant Mrs. Eva Moore Pope
Address 6406 Madawaska Rd.17. Cremation Date thereof July 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Maryland18. Funeral director W. R. R. HumphreyAddress 7557 Wis. Ave. Bethesda, Md.19. 7/8 19 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7 19 46 at 12:50 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6-10 19 46 to 7-7 19 46
and that I last saw him alive on 7-7 19 46Immediate cause of death acute bilateral
pyelonephritis - acute
perforated gangrenous
bladder
Due to cardiac decompensation
pulmonary edema
Other conditions hypertension
acute pyelonephritis
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Autopsy results See above Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

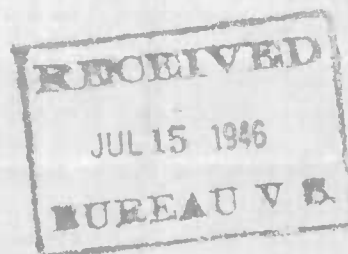
Means of injury Injured at work?

23. SIGNATURE W. J. Jones M. D. or otherAddress 546 Maple Ridge Rd. Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (728)

07155

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? two hours - six min.Hospital, institution, or street address where death occurred:
Washington Sanatorium Hosp.How long in hospital or institution? two hrs - six min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 201 Granville Drive
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Lillie May Moran

3. (b) Social Security Number

none

4. Sex _____ 5. Color or race _____ 6. (a) Single, married, widowed, or divorced _____

Fe cauc. widowed6. (b) Name of husband or wife Mr. John Moran (deceased)

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 31, 18868. AGE: Years 60 Months 1 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace Martinsburg, W. Va.
(Town, county, and state)10. Usual occupation Retired housewife

11. Industry or business _____

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Records - Washington San. Hosp.Address Takoma Park, Md.17. Shipment & burial Date thereof July 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green HillLocation Martinsburg, Berkeley Co., W. Va.18. Funeral director Maxwell E. HumphreyAddress Silver Spring, Md.19. July 16 1946 Registrar John D. ...

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946 at 1036 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1945 to July 12 1946and that I last saw him alive on July 12 1946Immediate cause of death Acute myocardial failureDURATION 7 hrs.Due to Rheumatic heart 40+ yrs.Due to w/ decompression 1 yr.+ myocardial sclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. McNeill, M.D. M. D. or other _____Address Silver Spring, Md. Date signed 7/12/46

RECEIVED

JUL 17 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?

Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Box 221
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Blanche Myers

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Charlton
 7. Birth date of deceased (mo., day, yr.) Oct. 30, 1876
 6.(c) If alive, give age

8. AGE: Years 70 Months 8 Days 8 If less than one day

9. Birthplace Chicago, Ill.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John A. Noble

13. Birthplace Ohio

14. Maiden name Mary B. Stewart

15. Birthplace Maryland

16. Informant C. E. Myers

Address Kensington - Md

17. Date thereof (month) (day) (year)

Cemetery or crematorium Greenwood

Location Wash. D.C.

18. Funeral director James Gay

Address 5406 Del. Ave. N.W. D.C.

19. Date rec'd by registrar 7/8 1946 2pm E. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 46 at 12:45 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 19 46, to July 8 19 46

and that I last saw him alive on July 7 19 46

Immediate cause of death Acute pulmonary edema DURATION 30 min.

Due to

Due to

Other conditions metastatic carcinoma

due to Ca. of uterus

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Marion Branthead M.D.

Address Silver Spring, Md. Date signed 7/8/46

RECEIVED
JUL 10 1946
BUREAU V.C.

8012-44.R.1
J.K.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Rockville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Feb. 31, 1945
 Hospital, institution, or street address where death occurred:
Waverley Sanitarium
 How long in hospital or institution? Feb. 31, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D. C.
 City or town Washington, D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 614 Maryland Ave. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None ✓

3. (a) FULL NAME

Isabella A. Myers

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced X6. (b) Name of husband or wife Chas E Myers7. Birth date of deceased (mo., day, yr.) Jan. 1st - 1870. 6. (c) If alive, give age 75 years8. AGE: Years 76 Months 6 Days 10 If less than one day 12 hrs. 50 min.8. Birthplace Washington D.C. (Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name John Mellis13. Birthplace Edinburgh, Scotland14. Maiden name Helen Kate Mellis15. Birthplace Edinburgh, Scotland16. Informant Mrs. M. E. WardAddress Rockville, Md.17. Burial Burial Date thereof 7/13/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GreenwoodLocation W. Capitol St. Wash. D.C.18. Funeral director R. P. HumphreyAddress Rockville, Md.19. 7/12 19 46 Im E. Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 - 1946 at 12:50 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 - 1946 to July 11 - 1946and that I last saw her alive on July 11 - 1946Immediate cause of death Bronchopneumoniaalso arterio-sclerosisDue to Chronic interstitial nephritisOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Wheeler & Huff Injured at work?23. SIGNATURE Bethesda, Md. M. D. or otherAddress Bethesda, Md. Date signed July 11/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 15 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07158

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Germantown Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Phena Neely

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Itzhak Neely

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 8th 1875

8. AGE:

Years

Months

Days

If less than one day

71128

hrs.

min.

9. Birthplace

Buckhannon. W Va.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER

12. Name

Thomas B Gawthrop

13. Birthplace

W Va.

MOTHER

14. Maiden name

Mary Chamber

15. Birthplace

W Va.

16. Informant

Delbert Neely

Address

Germantown. Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Waterloo Cemetery

Location

French Creek, W Va.

18. Funeral director

Whitescarver & Rundie

Address

Buckhannon. W Va.

19.

(Date read by registrar)

19.

46

Charles Y. Carke

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 46 at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2 " 46 to July 6 19 46and the last saw him alive on July 6 19 46

Immediate cause of death

Rocky Mountain Spotted Fever

DURATION

10 days

Due to

Due to

Other conditions

Seizure

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

in car

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edward H. Smith Washington D.C.

Address

1756 Eye St. N.W.

Date signed

7/6/46

RECEIVED
JUL 9 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1242

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town R. F. D. Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rockville Pike
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

LEONARD L. NICHOLSON JR.

3. (b) Social Security Number

No

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Slack
 6. (c) If alive, give age 53 years
 7. Birth date of deceased (mo., day, yr.) Sept. 27, 1872
 8. AGE: Years 73 Months 9 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation Retired - Real Estate

11. Industry or business

12. Name Leonard L. Nicholson Sr.
 13. Birthplace Washington, D. C.
 14. Maiden name Susan C. Brawner
 15. Birthplace Port Tobacco, Md.

16. Informant Slack Nicholson
 Address Rockville, Maryland

17. Burial Burial Date thereof July 18, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rockville Union Cemetary
 Location Rockville, Md.

18. Funeral director W. R. Brawner
 Address Rockville, Md.

19. 7/16 19 46 Mr. E. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 July 1946 to 15 July 1946
 and that I last saw him alive on 15 July 1946

Immediate cause of death Heart
 Due to Heart - chronic
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations None
 Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Charles T. Haller M.D.
 Address 1801 E. St. N.W. Date signed 7/26/46

CERTIFICATE OF DEATH

RECEIVED
JUL 19 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07160

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Montgomery
 City or town... Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hosp.
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... -
 City or town... Silver Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7800 Woodbury Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war... -

3. (a) FULL NAME

Mrs. Betty Jane Oberg

3. (b) Social Security Number

216-12-4129

4. Sex Female 5. Color or race Cauc. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife... John Michael Oberg
 6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) March 31 1922
 8. AGE: Years 24 Months 3 Days 27 If less than one day... hrs. ... min.
 9. Birthplace Sarver Pennsylvania
 (Town, county, and state)
 10. Usual occupation House wife

11. Industry or business

12. Name GUY S. HESSELGESSER
 13. Birthplace PENNA.
 14. Maiden name BLANCHE McCURDY
 15. Birthplace PENNA.

16. Informant Records - Washington San & Hosp
 Address Takoma Park, Md.

17. BURIAL Date thereof JULY 30 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory FORT LINCOLN
 Location PRINCE GEORGES CO. MD

18. Funeral director Warner E Pumphrey
 Address SILVER SPRING MD
 19. July 29 1946
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1946 at 11:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 21 1946 to July 27 1946
 and that I last saw her alive on July 27 1946

Immediate cause of death Acute Myelogenous Leukemia DURATION 1 1/2 yrs.

Due to...
 Due to...
 Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op. ...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. H. McNeill M.D.
 Address Silver Spring, Md. Date signed 7/27/46

RECEIVED

AUG 1 1946

BUREAU V B

94a

Reg. Diat. No. 216

Address 1150 C. Ave. W. Seattle, WA Date signed 5/21/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 24 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *5FB* A

07162

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____

City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 3017 38th St., S. E.

(If rural, give LOCATION)

2. (a) If veteran, name war 1st World War *(★)* ✓

3. (a) FULL NAME

Harold William ORCUTT

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary E. Orcutt

7. Birth date of deceased (mo., day, yr.) Sept 8, 1879

6. (c) If alive, give age _____ years

8. AGE: Years 66 Months 10 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Massachusetts
 (Town, county, and state)

10. Usual occupation Veteran

11. Industry or business

12. Name William B. Orcutt13. Birthplace Vermont14. Maiden name Kattie Wheeler15. Birthplace New Hampshire16. Informant Mrs. Mary E. OrcuttAddress 2017 38th St. S.E. Wash., D.C.

17. burial Date thereof 7-30-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. CHAMBERS *WWC*Address Georgetown, D.C.

19. 26 July 46
 (Date rec'd by registrar)

Mary Charlotte Smith
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 July 19 46 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 June 19 46 to 26 July 19 46
 and that I last saw h. in alive on 26 July 19 46

Immediate cause of death

ACUTE CORONARY OCCLUSION

DURATION

1 dayDue to ARTERIOSCLEROTIC HEART DISEASE10 yrs.

Due to

Other conditions CARCINOMA OF PROSTATEEXTENSIVE METASTASES

(Include pregnancy within 3 months of death)

5 yrs.

Major findings of operations

Date of op.

Autopsy results coronary occlusion; carcinoma of prostate
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury RE Fitzgerald Injured at work? _____23. SIGNATURE R. E. FITZGERALD, Lt. (jg) (MC) USN R

M. D. or other

Address USNH Bethesda, Md. Date signed 7-26-46

RECEIVED

AUG 5 1946

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

CERTIFICATE OF DEATH

07163

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Home or business or street address where death occurred:

4825 Rugby Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 4825 Rugby Avenue
(If rural, give LOCATION)2. (a) If veteran, name war ARMY

3. (a) FULL NAME

FLORENCE MAY PARKS

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Charles H. Parks7. Birth date of deceased (mo., day, yr.) Sept. 3rd., 1874
6. (c) If alive, give age..... years8. AGE: Years 71 Months 10 Days 12 If less than one day
..... hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name John S. Bremmnerman13. Birthplace Maryland14. Maiden name Sarah A. Odell15. Birthplace Maryland16. Informant John Raymond Parks (son)Address 4825 Rugby Ave., Bethesda, Md.17. Burial Date thereof July 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery Mount Zion CemeteryLocation Old Georgetown Rd., Bethesda, Md.18. Funeral director Wagner & HumphreyAddress Silver Spring, Maryland19. 7-17-46 19.....
(Date rec'd by registrar) Registrar H. E. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15-46 19..... at 8:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-9-46 19..... to 7-15-46 19.....
and that I last saw him/her alive on 7-15-46 19.....

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Arteriosclerosis & Coronary Degeneration

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. D. Jones M. D. or otherAddress 541 Maple Ridge Rd Bethesda, Md. Date signed 7-17-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Brookville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 29, 1946

8. AGE: Years Months Days If less than one day
1 hrs. 15 min.

9. Birthplace Olney, Montgomery Co. Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business _____

12. Name Quinn Morris Parsley

13. Birthplace Daisy, Maryland

14. Maiden name Edith Mildred Helphenstine

15. Birthplace Washington, D.C.

16. Informant Hospital records

Address

Burns Date (month) (day) (year) July 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. James Episcopal

Location Howard Co. Md

18. Funeral director Prof. W. Barber

Address Daytonville, Md

19. 7-29 19 46 Gertrude L. Law
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 46 at 7:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 19 46 to July 29 19 46 and that I last saw h.i. alive on July 29 19 46

Immediate cause of death _____

DURATION

Prematurity 5 mts.

Due to _____

Due to _____

Baby did not breathe but
Other conditions heart actions were present

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____

M. D. or other

Address Sandy Spring, Md Date signed 7/29/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07164

RECEIVED
AUG 14 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-4

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 323 15th St. S.E. Wash., D.C.
 (If rural, give LOCATION)

2.(a) If veteran, name war World War I ☒

3. (a) FULL NAME

Ira Mosley PAYNE V.B.P.

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced _____

8.(b) Name of husband or wife Minnie Payne

7. Birth date of deceased (mo., day, yr.) 15 May 1872 6.(c) If alive, give age _____ years

8. AGE: Years 74 Months 4 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation veteran

11. Industry or business _____

12. Name George Payne13. Birthplace Virginia14. Maiden name Cecilia Johnson15. Birthplace Virginia16. Informant Mrs. Minnie PayneAddress 323 15th St. S.E. Wash., D.C.

17. burial Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Alexander S. Pope 87Address 315 15th St. S.E. Wash., D.C.

19. 20 July 19 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 46 at 8:10pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 June 19 46 to 19 July 19 46

and that I last saw him alive on 19 July 19 46

Immediate cause of death Renal failure + uremia
terminal acidosis
 Due to Chronic glomerular nephritis. Curd.

Due to Syphilis; duration 30 years.

Other conditions hypertension; generalized arterio-sclerosis.

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

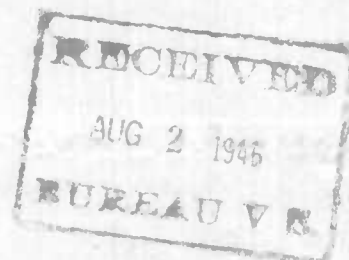
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE C.W. Thompson
C.W. THOMPSON, Lt. Cdr. (MC) USNR

Address USNH Bethesda, Md. M. D. or other _____
 Date signed 7-19-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07165
Reg. Dist. No. 218

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital
How long in hospital or institution? 1 mo. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. # 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry C. Peddicord

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Mar-6, 1890.

8. AGE:

Years

Months

Days

If less than one day

56327

hrs. min.

9. Birthplace

md.
(Town, county, and state)

10. Usual occupation

Vault maker

11. Industry or business

FATHER

12. Name

Thomas Peddicord

13. Birthplace

md.

MOTHER

14. Maiden name

Beth H Briggs

15. Birthplace

md.

16. Informant

Samuel Peddicord

Address

Gaithersburg md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7/7/46
(month) (day) (year)

Cemetery or crematory

Forest Oak Cemetery

Location

Gaithersburg md.

18. Funeral director

Gaithersburg md.

Address

Gaithersburg md.19. July 6
(Date rec'd by registrar)19. 46Abunda H. Cooke
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1946 at 11:45 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2, 1946 to July 3, 1946and that I last saw him alive on July 3, 1946Immediate cause of death Carcinoma of stomach

DURATION

One month

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of stomach with generalized metastasesAutopsy results Carcinoma of stomach with metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Barbara Moulton MD
M. D. or otherAddress Bethesda md. Date signed 7/3/46

RECEIVED
JUL 9 1946
BUREAU V. E.

File as Death

161a

07167

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF ~~STILLBIRTH~~ BIRTH AND DEATH

Reg. Dist. No. 216

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
U.S. Naval Hospital, Bethesda, Md.
Length of mother's stay in County.....
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State
County Washington, D.C.
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2919 Pa. Ave. S.E. ✓
(If RURAL give LOCATION)3. Name of child Carl PLUMB
5. Sex male 6. Twin or triplet --4. Date of birth July 2 1946 Hour 4:07 P.M.
7. No. of weeks pregnancy 9 months

FATHER OF CHILD

8. Full name Clarence P. Plumb
9. Color W-US 10. Age at time of this birth 30 yrs.
11. Usual occupation Potomac River Naval Command
Administrative advisor

MOTHER OF CHILD

12. Full maiden name Helen Hozempa
13. Color W-US 14. Age at time of this birth 27 yrs.
15. Usual occupation housewife16. Other children-born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 017. Did child die before labor? NO During labor? NO
18. Pregnancy, complications of none19. Labor: (a) Complications of Cord About neck +
outlet dystocia (b) Induced? no20. (a) Was there an operation for delivery? yes
(b) State all operations, if any. low forceps
episiotomy
(c) Did child die before operation? no
During operation? no21. Cause of ~~stillbirth~~ death 19 hours after delivery. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.(a) Fetal causes Marked Atelectasis & slight
cerebral hemorrhage
(b) Maternal causes Outlet dystocia22. I certify to the birth of this child who was born dead*
on the date and hour above stated and died 7-3-46.Signature Paul Peterson
Paul Peterson Capt (MC) US
(Specify if M. D., midwife, or other)Address Nav Hosp Bethesda, Md.23. (a) burial (b) Date thereof 7-5-46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Washington National24. (a) Funeral director W. W. Chambers
(b) Address 1100 Chapin St. N.W. Wash. D.C.25. (a) 7-3-46 (b) Mary C. Smith
(Date rec'd by registrar) (Registrar)26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per.....

* See Instruction C on stub.

CHILD LIVED 12 Hrs. 48 mins.

V. S. A10

7/9/46

JUL 10 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07166

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

2 Lyston Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 2 Lyston Drive
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

William Raymond Potter

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife May MeredithPotter6.(c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) April 14, 1888

8. AGE: Years Months Days It less than one day

58 2 26 hrs. min.9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Joseph K. Potter13. Birthplace Seeds, England14. Maiden name Kate Lombard15. Birthplace Montgomery, Alabama16. Informant Mrs. W. R. PotterAddress 2 Lyston Dr - Kensington, Md.17. BURIAL Date thereof JULY 13 - 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GlenwoodLocation WASHINGTON - D.C.18. Funeral director Warner & PumphreyAddress 8434 GA AVE. SILVER SPRING - MD.19. July 12 1946 Josephine Kucharski

(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6, to July 10 1946and that I last saw him alive on July 10 1946Immediate cause of death Cerebral HemorrhageDue to HypertensiveHeart Disease

Due to

Other conditions Chronicarthritis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isaacson Bannhead M.D.Address 9601 Sutton Rd. M. D. or otherDate signed 7/10/46

RECEIVED

AUG 2 1946

BUREAU VS

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. I 07 OCT 7 1946

CERTIFICATE OF DEATH

07168
Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State N.Y. County
City or town Elmira
(If outside city or town limits, write RURAL and give nearest town)
Street No. 510 W. Clinton St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

PULSIPHER, Edwina (n)

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Vance Pulsipher, PhMlc USN
7. Birth date of deceased (mo., day, yr.) unknown 6.(c) If alive, give age 19-23 years
8. AGE: Years 24 Months 23 Days 2 it less than one day 6 hrs. min.

9. Birthplace N.Y.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business
12. Name Martin Ford
13. Birthplace N.Y. dec.
14. Maiden name Catherine Walsh
15. Birthplace N.Y.

16. Informant husband: Mr. Vance Pulsipher, PhMlc
Address 510 W Clinton St., Elmira, N.Y.
17. removal Date thereof 7-19-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Elmira, N.Y.
18. Funeral director W. W. Chambers Benson
Address 1400 Chapin St., N.W., Wash., D.C.
19. 19 July 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 46 at 10:22P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
19 June 19 46 to 19 July 19 46
and that I last saw him in alive on 19 July 19 46
Immediate cause of death General Peritonitis
DURATION 4 wks
Due to Intestinal perforation 4 wks
Due to Regional ileitis 6 yrs
Other conditions Toxic Hepatitis 1 wks
Intestinal obstruction 4 wks
(Include pregnancy within 3 months of death)
Major findings of operations Drainage of abdominal cavity
for generalized peritonitis Date of op. July 8, 1946
Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?
23. SIGNATURE Dr. C. DeWitt S. (MC) USNR
Address USNH, Bethesda, Md Date signed 7/3/46

MARGIN RESERVED FOR BINDING

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VS A15

8/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 5 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0716316

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs.
 Hospital, institution, or street address where death occurred:
At home
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4713 Maple Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

MR. DAVID T. RABBITT

3. (b) Social Security Number

719-18-7672

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Mary C. Rabbitt
 6. (c) If alive, give age 74 years
 7. Birth date of deceased (mo., day, yr.) Dec. 12, 1871
 8. AGE: Years 74 Months 7 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Montgomery County, Maryland
 (Town, county, and state)
 10. Usual occupation Electrician - retired
 11. Industry or business Retired

12. Name Thomas T. Rabbitt
 13. Birthplace Montgomery County, Md.
 14. Maiden name Theresa Crown
 15. Birthplace Montgomery County, Md.

16. Informant Mrs. David T. Rabbitt
 Address 4713 Maple Ave., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 22, 1946
 (month) (day) (year)
 Cemetery or crematory St. Johns Church Cemetery
 Location Forest Glen, Maryland

18. Funeral director Mr. Renna Gumpfrey
 Address 7557 Wisconsin Ave., Bethesda, Md.

19. 7/21 46 John E. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 19, 19 46, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 39, to _____ 19 46and that I last saw him can alive on 20th July 19 46Immediate cause of death Crown Thrombosis

DURATION

12 daysDue to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John E. Jones M. D. or other _____Address 8016 Reisterstown Rd. Date signed 7/20/46

MARGIN RESERVED FOR BINDING

VS A15 J

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Monrovia
(If outside city or town limits, write RURAL and give nearest town)Street No. R#2 - Purdum
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Randolph

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Col. Single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 7, 19468. AGE: Years _____ Months _____ Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Olney, Montgomery Co. Md.
(Town, county, and state)10. Usual occupation Infant.

11. Industry or business

12. Name Arthur Edward Randolph13. Birthplace Barnesville, Maryland14. Maiden name Frances Beatrice Dorsey15. Birthplace Lewisdale, Md.16. Informant Hospital record

Address _____

17. Burial Date thereof July 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory PurdumLocation Purdum18. Funeral director W. BarberAddress afternoon19. July 9 19 46 Gertrude B. Lawler
(Date read by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 46 at 8: P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 46 to July 8 19 46and that I last saw her alive on July 8 19 46Immediate cause of death Stidus lymphaticusDue to Enlarged Thyroid

Other conditions _____

Major findings of operations _____

Autopsy results Enlarged Thyroid

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE hmsAddress Sandy Spring, Md. Date signed 7/9/46

RECEIVED

JUL 17 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07171

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since April 1941

Hospital, institution, or street address where death occurred:

16 Hesketh St. Chevy Chase, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 16 Hesketh St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Ella M. Ridgely

3. (b) Social Security Number

No

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Daniel M. Ridgely

7. Birth date of

deceased (mo., day, yr.)

March 13, 1853

6.(c) If alive, give age years

8. AGE:

Years

93

Months

4

Days

9

It less than one day

..... hrs. min.

9. Birthplace Wyoming, Del.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas L. Madden13. Birthplace Ireland, Del.14. Maiden name Mary L. Madden15. Birthplace Camden, Del.16. Informant Mrs. John R. ArnoldAddress 16 Hesketh St. Chevy Chase, Md17. Burial Date thereof July 24, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friends Burial GroundLocation Camden, Delaware18. Funeral director Rev. Reuben HumphreyAddress 7557 Wis. Ave. Bethesda, Md.19. 7/22 46 2pm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1946 at 1:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 7, 1946 to July 22, 1946and that I last saw her alive on July 22, 1946

Immediate cause of death

Coronary vascular -
renal disease

DURATION

5 yrs.

Due to

Due to

Other conditions Conjunctive Heart
Failure

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney E. Cousins MD

M. D. or other

Address 3921 Livingston St Date signed 7/22/46

RECEIVED
JUL 24 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47P

CERTIFICATE OF DEATH

07172

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ark. County _____
City or town Little Rock
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 East 10 Street,
(If rural, give LOCATION)
2. (a) If veteran, name war World War II ☒

3. (a) FULL NAME

RIDGEWAY, Claude Ben, Slc V-6 USNR

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Mrs. Martha Ridgeway
7. Birth date of deceased (mo., day, yr.) March 18, 1925 6. (c) If alive, give age _____ years
8. AGE: Years 21 Months 3 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Arkansas
(Town, county, and state)

10. Usual occupation Navy

11. Industry or business

12. Name Luster Ridgeway
13. Birthplace Ark.
14. Maiden name Lessie Gess
15. Birthplace Ark.

16. Informant wife: Mrs. Martha Ridgeway

Address Route #4, Box 398, Alexandria, Va.

17. removal Date thereof 7-8-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory _____

Location Little Rock, Ark

18. Funeral director W. W. Chambers & Co., funeral home

Address 1400 Chapin St., N. W., Wash., D.C.

19. 7-8 46 Mar Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 July 1946 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1946 to July 7 1946
and that I last saw him alive on 7 July 1946

Immediate cause of death Tumor mediastinum
malignant

DURATION

1 yr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Tumor mediastinum Malignant

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE Frank S. ASHBURN Lt. Cdr. (MC) USN

M. D. or other

Address USNH Bethesda, Md. Date signed 7-8-46

MARGIN RESERVED FOR BINDING

I

VS A15

7/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9-45-15

RECEIVED
JUL 12 1946
BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

07173

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 9 days
 Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 month, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... N.J. County...
 City or town... Irvington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 875 18th Avenue
 (if rural, give LOCATION) [Star]
 2.(a) If veteran, name war... ✓

3. (a) FULL NAME

Herbert Lewis SANDER CHPhoM USN

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs. Margaret E. Sander

7. Birth date of deceased (mo., day, yr.) January 11, 1903 6.(c) If alive, give age... years

8. AGE: Years 43 Months 6 Days 15 If less than one day hrs. min.

9. Birthplace... N.J.
 (Town, county, and state)

10. Usual occupation Navy

11. Industry or business

12. Name Henry C. Sander13. Birthplace N.J.14. Maiden name Emma Kerer15. Birthplace N.J. dec.16. Informant wife: Mrs. Margaret E. SanderAddress 2891 Hartford St., S.E., Wash., D.C.

17. burial Date thereof... 7-29-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. CHAMBERSAddress 1400 Chapin St., N. W., Wash., D.C.

19. 7-26 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 July 19 46 at 0645 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
17 June 19 46 to 26 July 19 46
 and that I last saw him alive on 26 July 19 46

Immediate cause of death Carcinoma, stomach
with metastasis
bronchopneumonia
purpura hemorrhagica
Gastrointestinal hemorrhage

DURATION

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Shuler

M. D. or other

Address USNH Bethesda, Md. Date signed 7-26-46

RECEIVED

AUG 2 1946

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

07174

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:Washington Sanitarium & HospitalHow long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Col. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1008 O'Leary Place N.W.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Sanger, Mr. Charles David

3. (b) Social Security Number

4. Sex Male 5. Color White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Hattie Long Sanger6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) April 28, 18828. AGE: Years 64 Months 2 Days 7 If less than one day
hrs. min.9. Birthplace Sangerville, Virginia
(Town, county, and state)10. Usual occupation Carpenter-foreman

11. Industry or business

12. Name Sanger, David I13. Birthplace Sangerville, Virginia14. Maiden name Gochenour, Elizabeth15. Birthplace Maryestown, Virginia16. Informant Washington Sanitarium & Hospital RecordsAddress Takoma Park, Maryland17. (Burial, cremation, or removal. Which?) Date thereof 7/8/46
(month) (day) (year)Cemetery or crematory St. Lincoln CemLocation The S. J. Hines Co.18. Funeral director The S. J. Hines Co.Address 2901-14th St. N.W. Washington, D.C.19. July 6th 1946 J. D. Sanger Registrar

(Date ready by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1946 at 3:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to 1946and that I last saw him alive on case on 1946Immediate cause of death Pulmonary embolism and pt. lobar pneumoniaDue to Fracture of 2nd lumbarDue to Noted

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-18-46Where did injury occur? St. Mary's Spinal Inst. (City or town) (State)Injured at home, farm, industry, public place (where?) St. Mary's Spinal Inst.Means of injury fall Injured at work? (home)23. SIGNATURE J. D. Sanger M. D. or otherAddress St. Mary's Spinal Inst. Date signed 7-5-46

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 17 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of
approximate age of deceased
is shown on
FILM No. I 06 JUL 31 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07175

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2222 N. Howard St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of
deceased (mo., day, yr.)8. AGE: Years 31 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace Unable to recall
(Town, county, and state)

10. Usual occupation

11. Industry or business any other

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burned
(By fire, cremation, or removal, Which?)Date thereof July 18, 1946
(month) (day) (year)

Cemetery or crematory

Address

18. Funeral director

Address

19. 7/18
(Date rec'd by registrar)19. 7/18
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 - 1946 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10, 1946 to July 15, 1946
and that I last saw him alive on July 15, 1946Immediate cause of death Lobar pneumonia +
extensive confluent lobular pneumonia
involving all lobes

DURATION

Due to Staphylococcus aureus

Due to

Other conditions Extensive cerebral hyperemia
and edema, septicaemia
(Include pregnancy within 3 months of death)Major findings of operations NoneAutopsy results Extensive glomerular pneumonia, lobar pneumonia, cerebral hyperemia, edema, septicaemia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work?

23. SIGNATURE

M. D. or other

Address Suburban Hospital Date signed July 16, 1946

RECEIVED
JUL 22 1948
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

07176

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Colesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

street address where death occurred:
Colesville Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Colesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Colesville Pike
(If rural, give LOCATION)

2.(a) II veteran, name war no

3. (a) FULL NAME

JAMES C. SKELLY

3. (b) Social Security Number

577-05-6137

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Emma A.

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) Sept. 21st. 1893

8. AGE:

Years

Months

Days

If less than one day

52107

hrs.

min.

9. Birthplace Brooklyn, N. Y.

(Town, county, and state)

10. Usual occupation Salesman11. Industry or business Real Estate12. Name James Skelly13. Birthplace N. Y.14. Maiden name Harriet Marshall15. Birthplace England16. Informant Mrs. Emma A. SkellyAddress R.F.D. 2 Silver Spring, Md.17. Burial Date thereof July 31st. 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Prince Georges Co. Md.18. Funeral director Warner E. RumphreyAddress Silver Spring, Maryland19. July 30 1946
(Date rec'd by registrar)Josephine M. Schaeffer
Registrar23. SIGNATURE Frank E. Brouhaert M.D.
Sup. Med. Exam. M. D. or otherAddress Leithsburg, Md. Date signed 7-28-46

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1946, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sup. Med. Exam. to 19
and that I last saw h. live on case 19

Immediate cause of death

Coronary occlusion

DURATION

died
suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

RECEIVED
AUG 2 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda - Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 hrs
 Hospital, institution, or street address where death occurred:
Suburban Hosp. 8600 Old Georgetown Rd.
 How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.R. #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs Susie Smith

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) ~~Single, married, widowed, or divorced~~
 6.(b) Name of husband Dudley Smith (Dec)
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) June 23, 1893
 8. AGE: Years 53 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business.....

FATHER 12. Name Henry Scott
 13. Birthplace Virginia
 MOTHER 14. Maiden name Fannie Sims
 15. Birthplace Virginia

16. Informant Alexander Hill
 Address Carterock, Md

17. Burial Date thereof 7/16/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mineral Cemetery
 Location Va

18. Funeral director A. N. Chambers Co.
 Address Washington D.C.

19. 7/13 1946
 (Date rec'd by registrar) Registrar Spm E. J. [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13- 1946 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12th 1946 to July 13 1946
 and that I last saw h. ER alive on July 13 1946

Immediate cause of death MYOCARDIAL FAILURE DURATION.....

Due to MYOCARDIAL HEART DISEASE OF UNKNOWN ETIOLOGY 4 YRS

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Leif H. E. De Lube M.D.

Address Suburban Hospital Bethesda, Md Date signed 13 July 1946

RECEIVED

JUL 16 1946

BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County MontgomeryCity or town Derwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Derwood
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Forest Alvin

3. (b) Social Security Number

Souders

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

Feb. 13th, 1931

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

193115416

hrs.

min.

9. Birthplace

Redland, Md.
(Town, county, and state)

10. Usual occupation

Student + Farm helper

11. Industry or business

FATHER

12. Name

Robert S. Souders

13. Birthplace

Pa.

14. Maiden name

Maude Schwartzbach

15. Birthplace

Md.

16. Informant

Maude S. Souders

Address

Derwood, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

7-11-46
(month) (day) (year)

Cemetery or crematory

Darnestown Cemetery

Location

Darnestown, Md.

18. Funeral director

Ernest C. Sautner

Address

Saithushum, Md.

19.

(Date registered by registrar)

19

July 9 46 Abada G. Cooke

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1946, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to July 9 1946and that I last saw him alive on July 19 1946

Immediate cause of death

Rocky Mountain spotted fever (tick fever)

DURATION

10 days

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Lathrop, M.D.

M. B. or other

Address

Rockville, Md.Date signed 7/9/46

RECEIVED
JUL 11 1946
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County 1017 N. Noyes Drive (Montg. Co.)

City or town Silver Sp. Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg.

City or town Silver Spring, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1017 N. Noyes Drive

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

Grace M. Stanton

3. (b) Social Security Number

No

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Timothy W. Stanton

8. (c) If alive, give age ? years

7. Birth date of

deceased (mo., day, yr.)

November 8, 1868

8. AGE:

Years

Months

Days

If less than one day

77

6

2

hrs. min.

9. Birthplace

Biddeford, Maine

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At home

FATHER

12. Name

Alphonso Patton

MOTHER

13. Birthplace

Maine

14. Maiden name

Josephine M. Bryant

15. Birthplace

Maine

16. Informant

Timothy W. Stanton

Address 1017 No. Noyes Dr. Sil Sprg, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 12, 1946
(month) (day) (year)

Cemetery or crematory

Port Lincoln

Location

Pr. Free Co. Md.

18. Funeral director

J. H. Hines Co.

Address 2901-14th St., N.W. Wash. D.C.

19.

Date rec'd by registrar

19 46

Josephine M. Knauff

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 July

19 46

at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3 July

19 46

to 6 July

19 46

and that I last saw him

alive on

6 July

19 46

Immediate cause of death

Cardiac Failure

DURATION

5 days

Due to

Myocarditis chronic
metastatic carcinoma10 yrs
6 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard J. Spur MD

M. D. or other

Address 2100 North Capitol St

Date signed 10 July 1946

MAINT AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUL 15 1946
BUFFALO

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring, Md - R.F.D. Colesville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Colesville
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Benjamin J. Thompson

3. (b) Social Security Number

214-03-6950

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Alice Tucker Thompson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1878

8. AGE: Years 67 Months 11 Days 18 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Benjamin F. Thompson13. Birthplace Maryland14. Maiden name Amanda Flook15. Birthplace Maryland16. Informant Mrs. Alice Tucker ThompsonAddress Colesville, Md.

17. Burial Date thereof July 27, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friends' CemeteryLocation Sandy Spring, Maryland18. Funeral director Warner E. PumphreyAddress Silver Spring, Md.

19. July 26 19 46 Josephine Chaeff
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 46 at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 24 - 1946 to July 24 1946
 and that I last saw him in death July 24 - 1946

Immediate cause of death

acute dilation heart

DURATION

5 min

Due to chr. myocarditis
& diabetes

15 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Charles Pumphrey

M. D. or other

Address Sandy Spring, Md. Date signed 7/25/46

RECEIVED

JUL 30 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

45 Poplar Ave.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

IDA HARE TURNER

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife.....

Morris C. Turner

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

June 15, 1862

8. AGE:

Years

Months

Days

If less than one day

84

0

22

hrs.

mle.

9. Birthplace.....

Balto., Md.

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

FATHER

12. Name.....

Michael Hare

13. Birthplace

Manchester, Md.

MOTHER

14. Maiden name.....

Mary Ann Miller

15. Birthplace

Manchester, Md.

16. Informant.....

Address

Bremerton, Wash.

17.

(Burial, cremation, or removal. Which?)

Crematory.....

Location

Balto., Md.

18. Funeral director.....

WM. J. TICKNER & SONS

Address

Balto., Md.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 7, 1946, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19, 1944, to July 7, 1946

and that I last saw him alive on July 7, 1946

Immediate cause of death.....

Cardiac dilatation

DURATION

1 day

Due to

Cardio-vascular-respiratory

Due to

Other conditions

alt eye-general debility

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Wm. A. Shannon M.D.

M. D. or other

Address..... Date signed July 7, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07182

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

733 Sligo Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 733 Sligo Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (a) FULL NAME

Mary Nettie Vaughan

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

X

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Nov. 13th. 1869

8. AGE:

Years

Months

Days

If less than one day

76

8

15

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Home maker

11. Industry or business

FATHER

12. Name

William H. Vaughan

13. Birthplace

Virginia

MOTHER

14. Maiden name

Martha Harwood

15. Birthplace

Virginia

16. Informant

Miss Ethel V. Wilkinson

Address

733 Sligo Ave. Silver Spring

17.

burial

Date thereof

7-31-1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rock Creek

Location

Washington, D. C.

18. Funeral director

Warner E. Pumphrey

Address

Silver Spring, Maryland.

19.

Date received by registrar

19

46

Josephine M. Schaeffer

Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 JULY 1946 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

OCTOBER 1946 to 28 JULY 1946and that I last saw him/her alive on 28 JULY 1946

Immediate cause of death

CEREBRAL HEMOR-RHAGE, MASSIVE

DURATION

3 DAYS

Due to

ESSENTIAL HYPERTENSIONUNKNOWNARTERIAL

Due to

ARTERIAL SCLEROSIS, GEN-UNKNOWNERALIZED

Other conditions

CONGESTIVE HEART FAILURE 10 MosDUE TO ABOVE AND MYOCARDIAL DEGENERATION

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

L. Marshall Curvillier Jr. MD.

M. D. or other

Address 8648 GEORGIA AVEDate signed 28 JULY 1946SILVER SPRING, MARYLAND

RECEIVED

AUG 2 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07183

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 5418 McKinley
(If rural, give LOCATION)2.(a) If veteran, name war No.

3. (a) FULL NAME

BETTY WAILES.

3. (b) Social Security Number

578-30-58834. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife No.7. Birth date of deceased (mo., day, yr.) August 22, 19266. (c) If alive, give age 19 years8. AGE: Years 19 Months 11 Days 25 If less than one day

hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Student.

11. Industry or business

12. Name Raymond Wailes13. Birthplace Wash. D.C.14. Maiden name Hortense Gaultthorpe15. Birthplace Warrenton, Va.16. Informant Mrs. Hortense WailesAddress 5418 McKinley, Bethesda, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 20, 1946
(month) (day) (year)Cemetery or crematory Congressional Cem.Location Washington, D.C.18. Funeral director A. H. Hines Co.Address 2901-14th St. N.W. Wash. D.C.19. 7-17-46 NE Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1946 at 79 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 - 1946 to July 17 - 1946and that I last saw him alive on July 17, 1946Immediate cause of death acute dilatation of heartDURATION 2 daysDue to Chronic endocarditis 15 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. G. Bayersfeld M.D. or otherAddress Bethesda, Md. Date signed 7/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUL 19 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3)

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Linden Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Linden Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

4. Sex Male5. Color or race Colored6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) February 18, 1921

6.(c) If alive, give age _____ years

8. AGE: Years 25 Months _____ Days _____
less than one day _____ hrs. _____ min.9. Birthplace Martinsburg, Mont. Md.
(Town, county, and state)10. Usual occupation Truck Driver

11. Industry or business _____

12. Name F. William Washington13. Birthplace Va.14. Maiden name Carrie Hallman15. Birthplace Maryland16. Informant Clarence Washington (Bro)Address 927-26th St. Wash. D.C.17. Burial Date thereof July 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Martinsburg Ch. Cem.Location Martinsburg, Md.18. Funeral director R. L. GaudenAddress Rockville, Md.19. July 20 19 46 Josephine Thaeff

Date rec'd by registrar _____ Registrar _____

3.(b) Social Security Number

214-16-7960

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 46 12:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med exam case 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____

DURATION

Due to Asphyxia following (accident)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 7-18-46Where did injury occur? Rock Creek Road Glen Mary Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury drowning Injured at work? no23. SIGNATURE Frank J. Donahue M.D.Dep Med Exam M. D. or other _____Address Washington Md Date signed 7-19-46

RECEIVED

JUL 23 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07185

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Nebraska County

City or town Omaha
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1219 S. 27th Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Frank Joseph WEILAND

3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Frances Weiland

7. Birth date of deceased (mo., day, yr.) May 22 1912 6.(c) If alive, give age years

8. AGE: Years 34 Months 1 Days 27 If less than one day
hrs.min.

9. Birthplace Nebr.
 (Town, county, and state)

10. Usual occupation Navy11. Industry or business U.S. Navy12. Name Frank Weiland13. Birthplace Mo.14. Maiden name Camilla Bruno15. Birthplace Ill.16. Informant Mrs. Frances WeilandAddress 2803 Terrace Rd. S.E. Wash., D.C.

17. Funeral Removal Date thereof 7/22/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary'sLocation Omaha, Nebraska

18. Funeral director W. W. CHAMBERS
Dunk Chapin Funeral Home Omaha, Neb.

Address 1400 Chapin St., N. W., Wash., D.C.

19. 19 July 46
 (Date rec'd by registrar)

23. SIGNATURE T. J. Bridges, Lt. (jg) USNR

Address USNH Bethesda, Md. Date signed 7-19-46

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 July 19 46, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12 July 19 46, to 19 July 19 46

and that I last saw him in alive on 19 July 19 46

Immediate cause of death Brain tumor -
Glioblastoma multiforme - right
frontal, and intracranial
hemorrhage

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

T. J. Bridges, Lt. (jg) USNR

M. D. or other

Date signed 7-19-46

RECEIVED
JUL 24 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83-2

07186

223

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

County MontgomeryCity or town Federal Park - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louis George Mills

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

June 12, 1889

8. AGE:

Years

57

Months

1

Days

✓

If less than one day

hrs.

min.

9. Birthplace

Canada
(Town, county, and state)

10. Usual occupation

Court Reporter

11. Industry or business

George Mills

12. Name

13. Birthplace

Canada

14. Maiden name

Emily Hancock

15. Birthplace

England

16. Informant

Mrs. Louis Geo. Mills

Address

101 Grant Ave. Federal Park

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 17, 1946
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Va.

18. Funeral director

Arthur Walters

Address

754 Carey St. Federal Park

19. Date rec'd by registrar

July 15, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Federal Park - Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

101 Grant Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 14, 1946

at

11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12, 1946

to

July 14, 1946

and that I last saw him alive on

July 14, 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

2 hrs.

Due to

arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Shetty Med.

Address

6911 5th St. N.W.

Date signed

July 14, 1946

Washington DC

RECEIVED

JUL 17 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

07187

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1829 W St. S.E. Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Arthur Emerson WILSON V.B.P.

3.(b) Social Security Number

4. Sex

male

5. Color or race

W*US

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Mrs. Arthur E. Wilson

7. Birth date of deceased (mo., day, yr.)

1 April 1892

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

54318

..... hrs.

..... min.

9. Birthplace Maine

(Town, county, and state)

10. Usual occupation veteran

11. Industry or business

FATHER
MOTHER12. Name John Wilson (dec.)13. Birthplace Maine14. Maiden name Sara E. Emerson (dec.)15. Birthplace Maine16. Informant Mrs. Arthur E. WilsonAddress 1829 W St. S.E. Wash. D.C.17. Burial
(Burial, cremation, or removal. Which?)Date thereof July 22, 1946
(month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington National, Va.18. Funeral director W.W. CHAMBERS CO.Address 517 11th St. S.E. Wash. D.C.19. 20 July 19 46
(Date rec'd by registrar)Mary Charlotte Smith
Registrar23. SIGNATURE J. B. Shuler
J. B. SHULER, Comdr. (MC) USNM. D. or other 7-20-46
Address Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 July 19 46 at 9:00 p.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

22 May19 46to 19 July19 46and that I last saw him in alive on 19 July 19 46Immediate cause of death Carcinoma of right breast with metastasis to pleura and wide spread skeletal metastasis
Due to Inanition and emaciation

DURATION

2 yrs2 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

RECEIVED

JUL 29 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 4925 Upton St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Wolfe, Richard S.

3.(b) Social Security Number

4. Sex Male 5. Color or race Cauc. 6.(a) Single, married, widowed, or divorced Widowed8.(b) Name of husband, or wife Rebecca Wolfe
(deceased) 6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) March 9, 18588. AGE: Years 88 Months 4 Days 6 If less than one day
..... hrs. min.9. Birthplace Hagerstown, Maryland
(Town, county, and state)10. Usual occupation Retired - Star Newspaper11. Industry or business Evening Star Reporter12. Name -13. Birthplace -14. Maiden name -15. Birthplace -16. Informant Washington Sanitarium and HospitalAddress Takoma Park, Maryland17. Removal Removal Date thereof July 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.18. Funeral director Martin W. ThompsonAddress 1300 N. St. N.E.19. July 15, 1946 J. W. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 3, 1946 to July 15, 1946and that I last saw him alive on July 15, 1946Immediate cause of death circulatory collapse

DURATION

3 daysDue to acute pulmonary edema 3 dayshypertensive cardiovascularDue to renal disease & heart failurearteriosclerosisOther conditions Right renal calculi

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE DeVoe Kephner Meade M. D. or otherAddress 504 Julius Ave. Date signed July 15, 1946Annex Park, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 17 1946

BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... MONTGOMERY

City or town... SILVER SPRINGS
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... M.D. County... MONTGOMERY

City or town... SILVER SPRINGS
(If outside city or town limits, write RURAL and give nearest town)

Street No... 9300-51-ANDREWS WAY
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JACOB YAFFE

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6.(b) Name of husband or wife... SARAH YAFFE

7. Birth date of deceased (mo., day, yr.) 5.(c) If alive, give age... 65 years

1881

8. AGE: Years Months Days If less than one day
65 hrs. min.

9. Birthplace... RUSSIA
(Town, county, and state)

10. Usual occupation... RETIRED

11. Industry or business

12. Name... ABRAHAM YAFFE

13. Birthplace... RUSSIA

14. Maiden name...

15. Birthplace... Russia

16. Informant... SIDNEY A KLINE

Address... 9300-51 ANDREW WAY

17. (Burial, cremation, or removal. Which?) Date thereof... Burial July 29 1946
(month) (day) (year)

Cemetery or crematory... Everest Road Cemetery

Location... Washington, D.C.

18. Funeral director... B. M. M. & Son

Address... 3501-14 24TH W

19. (Date rec'd by registrar) 1946 Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... July 28 1946 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1946 to July 28 1946

and that I last saw him alive on July 28 1946

Immediate cause of death... Pulmonary
hemorrhage

Due to... Carcinoma of

Due to... Lung

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Lawrence Thomas M.D.

Address... 8019 Eastern Ave

Date signed... 7/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY: WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUL 30 1946

BUREAU U.S.

Dr. Thomas
8019